Proud Tradition Promising Future

NEW PRAGUE AREA SCHOOLS

Concussion Care Plan

Patient Name: _____ **Grade**: _____ **Date of Birth:** _____

Date of Injury: _____ **Date of Evaluation**: _____ **Cause of Injury:** _____

***The patient listed above was evaluated for a concussion/head injury. It has been determined that:*

☐ The patient **DID NOT** sustain a concussion and may resume regular activity.

☐ The patient **DID** sustain a concussion at the time of injury. Prior to returning to full activity the patient must complete the following stepwise program to gradually increase exertion levels to return safely to normal activity. **Date of Next Appointment**: _____

☐ The patient has been cleared to initiate the **Return to Learn** protocol **(Please indicate/check appropriate step)**

- ❑ **Step 1 – Complete Cognitive and Physical Rest**: Stay home from school and limit mental exertion such as computer use, texting, video games, and homework. No driving.
- ❑ **Step 2 – Light Mental Activity**: Stay home from school. Limit mental exertion. No driving. Progress to the next level when able to complete 30 minutes of mental exertion without an increase in symptoms*.
- ❑ **Step 3 – Part Time School - maximum accommodations:** rather than postpone academics. Scheduled rest breaks and additional time when needed. No band, choir, or shop class. Progress to the next level when able to handle 45 minutes or more of mental exertion without an increase in symptoms.
- ❑ **Step 4 – Part Time School - moderate accommodations:** shortened academic day, modified classroom academics and testing. No standardized assessments. No band, choir, or shop class. Progress to the next level when able to handle 60 minutes or more of mental exertion without an increase in symptoms*.
- ❑ **Step 5 – Full Time School - minimal accommodations**: Routine tests appropriate. May require additional support in academically challenging classes. Progress when able to handle all class periods in succession without an increase in symptoms (headache, nausea, dizziness, visual changes, difficulty concentrating, feeling foggy, increased irritability, or difficulty with sleep)
- ❑ **Step 6 – Full Time School – limited to no accommodations:** full homework and testing. Monitored.

☐ The patient **DID** sustain a concussion at the time of injury. The patient has **SUCCESSFULLY COMPLETED** all the Return to Learn steps as listed above and **MAY RESUME** regular academic activity.

☐ The patient has been cleared to initiate the **Return to Play** protocol. Progress to the next step if symptom-free for 24 hours after completing each step. (Typical post-concussion symptoms can include, but are not limited to: headache, nausea, dizziness, visual changes, difficulty concentrating, feeling foggy, increased irritability, or difficulty with sleep.)

NOTE: RETURN TO LEARN STEPS MUST BE STARTED PRIOR TO OR COINCIDING WITH RETURN TO PLAY STEPS.

- ❑ **Step 1. Physical and cognitive rest (recovery):** functional exercise (may only do activities of daily living)
- ❑ **Step 2. Light aerobic activity (increase heart rate):** 15-20 minutes, no resistance (e.g.: brisk walking, light jog, etc.)
- ❑ **Step 3. Sport-specific, non-contact exercises (add movement and duration):** 30-45 minutes, no weight lifting, no head contact (e.g.: skating in hockey, dribbling in soccer, swimming in pool)
- ❑ **Step 4. Non-contact practice (add coordination, resistance, and mental tasks):** 1-2 hours, progression to more complex drills, may start progressive resistance training (e.g.: no contact/tackling or red jersey practice)
- ❑ **Step 5. Full-contact practice (add contact, build confidence, and assess skills):** Following health care provider clearance, the athlete may participate in normal training activities; full exertion, full pads and full contact practice.
- ❑ **Step 6. Return to play** (full activity without restrictions)

☐ The patient did sustain a concussion at the time of injury. The patient has **SUCCESSFULLY COMPLETED** all the **Return to Learn** and **Return to Play** steps as listed above and **MAY RESUME** regular activity.

Date:_____ **Provider Signature**:_____ **Provider Printed Name:** _____

Clinic Name:_____ **Provider Phone**:_____ **Provider Email:** _____

Updated: 8/30/19