St.Charles Hospital

ThinkSmart! **CONCUSSION CARE PLAN (SCHOOL)**

Pediatrician/PCP:	**School:**	**Date of Injury:**

School - the following is recommended:

- ☐ **Full return to school without restrictions**
- ☐ **No school:**_____.
- ☐ **Return to School with restrictions as below:**
- ☐ Return to school half days on:_____.
- ☐ No attending the following classes: _____.
- ☐ Extra time to complete coursework/assignments and tests (i.e. time and a half).
- ☐ Maximum length of nightly homework _____minutes.
- ☐ No tests or quizzes.
- ☐ No computer work.
- ☐ No Smart Board-provide written notes.
- ☐ No sitting in music rooms or gymnasium while class is in progress.
- ☐ Return to tests/quizzes at 1 test/quiz per day for make ups starting on:_____.
- ☐ Take rest breaks as needed during the day.
- ☐ Lunch in a quiet location.
- ☐ 5 minute early dismissal from classes
- ☐ See the school nurse to be dismissed early or rest should there be any increase in symptoms.
- ☐ Request meeting of 504 or School Management Team to discuss this plan and needed supports.
- ☐ _____
- ☐ _____

Return to Sports/Physical Activity

- You should NEVER return to play if you still have ANY symptoms. Be sure that you do not have any symptoms at rest and while doing any physical activity and/or activities that require a lot of thinking or concentration.
- Be sure that the PE teacher, coach, and/or athletic trainer are aware of your injury and symptoms.
- It is normal to feel frustrated, sad, and/or angry because you can't return to sports at this time. As with any injury, a full recovery will reduce the chances of getting hurt again. You would probably agree that it is better to miss one or two games than the whole season.

Physical Activity - The following is recommended:

- ☐ Do not return to PE Class or team sports (practices or games).
- ☐ No sitting at practice or games.
- ☐ No sportsfolio
- ☐ Return to PE Class and team sports with No restrictions.
- ☐ Gradual return to sports practices under the supervision of an appropriate health care provider (athletic trainer or physical therapist). – see below "**Gradual Return to Play Plan**"
- ☐ _____
- ☐ _____

Medications prescribed:_____

	Additional Instructions:
	Return to this office:
	Referral made to ___Neurosurgery ___Neurology ___Psychiatrist ___Other _____.
	Refer for neuropsychological testing

Instructions completed by _____ Date:_____

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Adapted from "Heads Up: Brain Injury in Your Practice" toolkit developed by the Centers for Disease Control and Prevention (CDC)

St.Charles Hospital

***ThinkSmart!* Concussion Management Program**
Return to Play Progression

Student Name:_____ **Age:**_____ **M / F** **DOB:**_____

MD:_____ **Sport**: _____ **School District**:_____

Assessment Table: Assessments to be completed before and after exertion. Stage is successfully completed once the athlete can perform the required level of exertion without any change in status or increase in symptoms. Students should be symptom free both before and after exertion.

Balance Assessment Guide:	
Romberg eyes open	Single leg stance eyes closed
Romberg eyes closed	Tandem Gait Forward
Single leg stance eyes open	Tandem Gait Reverse
Romberg and single leg stance with 20 second hold	

Cognitive Assessment Guide:	
Orientation	Serial 5,6,7, or 8 (age approp.)
Immediate 3 word recall	Trails a1, b2, c3, etc
WORLD in reverse	Delayed 3 word recall
Months in reverse	

RTP Stage	**Date Performed**	**Passed**	**Failed**	**Comments**
2				
Repeat if needed				
3				
Repeat if needed				
4				
Repeat if needed				
5				
Repeat if needed				

RTP Summary:

☐ **Student successfully completed the full return to play progression.**

☐ **Student was unable to complete the full return to play progression as indicated above. Student to follow up with physician.**

Additional Comments:_____

_____

ATC:_____ _____
Print Name Signature

Date:_____

Upon completion fax to:
Dr._____
Fax Number:_____

St.Charles Hospital

ThinkSmart! Concussion Management

Return to Play Protocol/ Prescription

Patient Name:_____ **Patient DOB:**_____

Diagnosis:_____

RTP to begin on or after:_____ **(date)**

# of days/ stage	Stage	Activity
[redacted]	1	No Physical Education or Team Sports until further notice. Objective is recovery.
	2	Light aerobic exercise: Walking, swimming, stationary cycling or other aerobic activities keeping intensity <70% maximum permitted heart rate. No resistance training. Objective to increase HR.
	3	Sport-specific exercise: Running drills, various sports drills and activities. No head impact activities. Objective is to add movement.
	4	Non-contact training drills: Progression to more complex training drills, passing drills, jumping drills. May start progressive resistance training. Objective is exercise, coordination and cognitive load.
	5	Full-contact practice: Participate in normal training activities. Objective is to restore confidence and assess functional skills. ☐ To Be Completed with ATC and team – SPORT PRACTICE ☐ To be simulated with a PT in clinic
	6	Full Unrestricted Activities. Following medical clearance, return to full contact activities in competition environment.

Comments/special instructions:_____

_____

_____

_____

DO NOT progress to the next level of exertion unless you are symptom free for the recommended amount of days. If symptoms return during or after exerting, cease activity and rest. You may resume activity at a lower level the following day if you are symptom free, beginning the return to play progression again.

Please contact your physician if symptoms recur or worsen.

Physician Signature: _____ **Date:**_____