Archbishop Wood High School Concussion Management Team
Current Parent/Guardian Contact Information Form

STUDENT NAME:_____ BIRTH DATE:_____
ADDRESS:_____
_____

GRADE: _____ SECTION: _____ STUDENT #:_____

MOTHER'S NAME:_____ CELL PHONE:_____
EMAIL ADDRESS:_____ WORK PHONE:_____

FATHER'S NAME:_____ CELL PHONE:_____
EMAIL ADDRESS:_____ WORK PHONE:_____

DOCTOR'S NAME:_____ PHONE:_____

DENTIST'S NAME:_____ PHONE:_____

HEALTH CARE PROVIDER AND #:_____

PREFERRED HOSPITAL:_____

DATE CONCUSSION SUFFERED:_____

CAUSE OF CONCUSSION: _____

IS THIS THE STUDENT'S FIRST CONCUSSION? _____

IF NOT, PLEASE LIST ALL PREVIOUS CONCUSSIONS:
_____

Medical concerns or medication(s) being taken:
_____
_____

Signature(s):

_____
Father / Parent or guardian Date

_____
Mother / Parent or guardian Date

Archbishop Wood Concussion Management Team
Consent To Obtain/Release Medical Information

STUDENT NAME: _____

DATE OF BIRTH: _____

Sound communication between and among all health care providers is key to providing the best treatment to a concussed student. This release is provided to encourage communication between the treating medical physician and the Archbishop Wood Concussion Management Team.

****** RELEASE ******

As parent or legal guardian of _____, I grant permission for the office of _____ to release information pertinent to the health care of my student to the members of the Archbishop Wood Concussion Management Team.

I understand that the release of information may be in person, in the form of written or verbal communication, over the telephone, in electronic form, via letters or documents, and/or via reproductions of originals of written material including but not limited to X-Rays and MRIs.

_____ _____

Parent/Guardian Signature Date

This consent is valid for one (1) year unless withdrawn in writing.
Any and all information shared will be considered confidential in nature, and every effort will be made to maintain confidentiality.

Physician's Name: _____

Address: _____

_____

Phone: _____

Archbishop Wood High School Concussion Management Team
Policy for Student Recovery from a Concussion

____ 1. When a student is diagnosed with, or has symptoms of, a concussion, the student should be seen immediately by an **appropriate medical professional**, which is defined in the Pennsylvania Safety in Youth Sports Act as follows: (1) a licensed physician who is trained in the evaluation and management of concussions or a licensed or certified health care professional trained in the evaluation and management of concussions and designated by such a licensed physician; or (2) a licensed psychologist neurpsychologically trained in the evaluation and management of concussions or who has postdoctoral training in neuropsychology and specific training in the evaluation and management of concussions (hereinafter referred to as "appropriate medical professional").

____ 2. The student's parent or guardian should contact the Archbishop Wood Concussion Management Team at AWCMT@archwood.org and read and follow all of the instructions on the AWCMT's website by logging on to www.archwood.org, and clicking the Student Life Tab to access the information on the AW Concussion Management Team.

____ 3. If the student who is diagnosed with, has symptoms of, and/or requires accommodations due to, a concussion is absent from school, his or her parent/guardian should contact The Student Service office at (215) 672-5050 ext. 255 to report the absence.

____ 4. If the student who is diagnosed with, or has symptoms of, a concussion, returns to school within 2 days, he or she should report to the school nurse's office with any doctor's notes. The nurse will inform the AWCMT.

____ 5. If the student who is diagnosed with, or has symptoms of a concussion, is absent from school for more than 2 days, a re-admittance meeting will take place with the AWCMT. The student's parent/guardian should call (215) 672-5050 ext. 262 to schedule the meeting.

____ 6. Prior to the re-admittance meeting, the student's parent/guardian should gather all required information from the student's appropriate medical professional using the AWCMT Concussion Re-Admittance Form, fill out the AWCMT Current Parent/Guardian Contact Info. Sheet, and gather any and all notes pertaining to the student, including current medications, learning accommodations, etc.

____ 7. All necessary arrangements will be made at the re-admittance meeting for both physical and learning accommodations. A plan will be put in to place to help the student return to his or her pre-concussive state as soon as possible.

____ 8. The AWCMT will schedule an appointment for the student to retake his/her ImPACT Concussion test. (Upon request by a student's parent/guardian, the student's test results, as well as Baseline scores, can be provided to the student's parent/guardian for review by the student's appropriate medical professional).

____ 9. The student and/or his/her parent/guardian should schedule a follow up exam with the student's appropriate medical professional, and provide the date of his/her follow up exam to the AWCMT.

____ 10. The student should bring updated information from his/her appropriate medical professional to the school nurse's office, to be shared with AWCMT (at least every 2 weeks).

____ 11. Once the student is asymptomatic at rest, and cleared by his/her appropriate medical professional, he/she must provide the AWCMT with a Concussion Re-Admittance Form. At that point, the student can begin the following "Return to Play" Protocol:

1. Light Aerobic Exercise
2. Moderate Aerobic Exercise
3. Strenuous Aerobic Exercise and Agility Drills
4. Non-contact Practice
5. Full-contact Practice
6. Reinstatement to Game Participation

If a student is unable to, or fails to, perform any step of the Return to Play Protocol, he/she must return back to Step 1 of the Return to Play Protocol. This Return to Play Protocol will be performed and supervised by the school's Athletic Trainer if the student is playing a school sanctioned PIAA sport at Archbishop Wood.

Parent/Guardian Questions or Notes:

_____

_____

_____

Archbishop Wood Concussion Management Team
Concussion Re-Admittance Form

Student Name:_____ **Date:**_____

Restrictions/Recommendations:

Attendance
____ Please excuse from school until at least _____
____ No school until symptom free or significant decrease in symptoms for 24-48 hours
____ Shortened school day when the student returns to school until at least _____
____ Full school days as tolerated

Breaks
____ Allow to go to the nurse's office if symptoms worsen
____ Allow to go home if symptoms don't subside after resting for 1 hour

Workload Reduction
____ No homework
____ Student is allowed to attempt work at home, but do not provide deadlines for assignments

Testing
____ No testing (classroom or standardized)
____ Allow extra time to complete tests, quizzes, and assignments
____ No more than 1 test per day
____ Testing in a quiet place
____ Oral testing
____ Open book/notes testing

Note Taking
____ Needs a copy of class notes either from the teacher or another student
____ Allow to participate in class only by listening with no active note taking

Visual/Audible Stimuli
____ No Smart Boards, projectors, computers, TV screens or other bright screens
____ Enlarged font when possible
____ Avoid loud and crowed places (hallways, auditorium, cafeteria) as needed. Student may need to leave class early to move from class to class in an empty hallway.

Physical Activity
____ No Physical Education or participation in sports
____ May begin "Return to Play" Protocol

Meeting Requested
____ Request meeting of Archbishop Wood Concussion Management Team to discuss plan

Additional Recommendations:

_____

I will provide an update of the student's status after my next evaluation on _____. I hereby certify that I am trained in the evaluation and management of concussions.

Physician's Signature: _____ Date: _____

No Restrictions– Full Return to Academic Responsibilities and Physical Activity:

Student is cleared to return to full academic responsibilities and full physical activity, physical education, practice, training and competition with no restrictions. I hereby certify that I am trained in the evaluation and management of concussions.

Physician's Signature: _____ Date: _____

Archbishop Wood High School Concussion Management Team
Return To Athletic Participation Form

Player with Concussion/Suspected Concussion: _____

Sport in Which Injury Occurred: _____

Number of Previous Concussions or Suspected Concussions: _____

PRACTICE-RELATED INJURY INFORMATION

Date/Time Injured Player was removed from Practice: _____

Date/Time if Injured Player was returned to Practice: _____

Name of Person authorizing return to Practice:_____

Brief Description of Symptoms Noted and Sideline Evaluation:

_____

_____

_____

GAME-RELATED INJURY INFORMATION

Date/Time Injured Player was removed from Game: _____

Period/Quarter/Half when Player was removed from Game: _____

Date/Time if Injured Player was returned to Game: _____

Period/Quarter/Half if the Injured Player was returned to Game: _____

Name of Person authorizing return to Game: _____

Brief Description of Symptoms Noted and Sideline Evaluation:

_____

_____

_____

PHYSICIAN MEDICAL RELEASE FORM

Player Name with Concussion/Suspected Concussion: _____

Name of School: _____

Name of Sport: _____

Date of Initial Medical Evaluation: _____

The Return-To-Play Release:

On this _____ day of _____, 20___, I hereby authorize and clear the above-named student to return to play and participate in athletic competition without restrictions. I hereby certify that I am trained in the evaluation and management of concussions.

Signature of Physician: _____

Printed Name of Physician: _____

Office Address: _____

_____

Telephone Number: (_____)_____