



# Concussion Policy & Procedures Handbook

## Concussion Oversight Team

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# Cypress-Fairbanks Independent School District

## Head Injury Assessment, Prevention, Management, and Return to Play Guidelines

The following policy, procedures, and guidelines on assessment, prevention, and management of head injuries, as well as return-to-play guidelines have been developed in accordance with Texas Education Code Sec. 38. 151-160 and the goals of CFISD athletics and Health Services to ensure the well-being of each student athlete. The risk of repeated concussions and second impact syndrome is also a concerning factor. These two problems can have long lasting, and even terminal effects, on athletes.

Continuing to play with the signs and symptoms of a concussion leaves athletes especially vulnerable to greater injury. There is an increased risk of significant damage from another concussion before completely recovering from the first one. This can lead to prolonged recovery, or even severe brain swelling (second impact syndrome) with devastating and even fatal consequences. It is well known that adolescent or teenage athletes will often under report symptoms of injuries (including concussions). As a result, education of administrators, coaches, parents, and students is the key for a student athlete's safety.

### **Purpose**

The CFISD Athletic Department recognizes that concussions pose a significant health risk for student athletes. Therefore, the Athletics Department has implemented policies and procedures to deal with the assessment, prevention, management, and return-to-play guidelines for student athletes who have sustained a head injury. The physical exam, symptom scaling, follow up testing, and a gradual return-to-play protocol will all be used in conjunction with sound clinical judgment and on an individual basis to determine when it is safe for an athlete to return to competition.

### **Prevention**

In an effort to reduce the number of head injuries in CFISD the district insists that "safety comes first." The following procedures will be used as a guideline to assist in the prevention of head injuries.

- Request accurate information from parents/guardians on physical form
- Teach and practice safe playing techniques
- Teach athletes the dangers of playing with a concussion
- Obtain acknowledgment from parents/guardians that they have reviewed the concussion information provided by UIL
- Encourage athletes to follow the rules of play and to practice good sportsmanship at all times;
- Ensure athletes wear the right protective equipment for their activity (such as helmets, padding, and mouth guards)
- Ensure all headgear is NOCSAE certified
- Ensure headgear fits the individual, and is secured properly to the individual
- Ensure that for all sports that require headgear, a coach or appropriate designee periodically checks headgear to verify air bladders are functional and are appropriately filled; and
- Periodically verify padding is in proper working condition.

Although all head injuries cannot be prevented, CFISD is working proactively in order to reduce the number and severity of head injuries that do occur.

## **Reporting Head Injuries**

It is important that the student athlete/parent report all head injuries received to the athletic trainer/ middle school coach. This includes any head injury that occurs out of the school environment. It is important that any head injuries be reported before a student engages in physical activity.

## **Initial Athlete Evaluation/Assessment**

In all cases in which a head injury is suspected, the athlete must be removed from athletic participation and an **initial assessment** will take place. Following the initial assessment, the need for further medical evaluation will be determined in accordance with Texas Education Code Sec. 38. 151-160. If the Return to Play Protocol is initiated, the athlete will **NOT** be allowed further participation on the day of injury. CFISD Head Injury Notification & Physician Clearance for Return to Play (RTP) Protocol will be provided, and parents/guardians will be contacted.

## **Health Care Professional Evaluation**

Evaluation by a physician should include a neurological and a functional test per Texas Education Code Sec. 38. 151-160. A neurological test should include, but is not limited to, eye movements, pupil response, balance (static and dynamic), hearing, and vision. A functional test should include, but is not limited to, heel toe walking, jogging, and progressive functional activity.

## **School Evaluation**

Any athlete that has sustained a head injury is required to report to the high school athletic trainer or middle school nurse daily. The athletic trainer will be responsible of notifying the high school nurse of the head injury.

## **Treatment/ Rehabilitation**

CFISD athletes who sustain a head injury will be restricted from UIL athletics until successful completion of the UIL RTP. CFISD strongly recommends that students with head injuries refrain from outside activities such as recreational exercise and club sports.

Additionally, treating physicians may recommend that a student should video games, television viewing, computer usage, and cell phone usage, including text messaging.

Classroom accommodations, if deemed necessary by the treating physician, will be communicated with the students' teachers and academic accommodations will be made per the treating physicians' instructions. These academic accommodations will expire upon the completion of Level 4 of the RTP unless otherwise specified by the treating physician

## **Follow-up Evaluation**

CFISD athletes who have sustained a head injury will be required to follow the return-to-play guidelines. Athletes will be required to check in with their athletic trainer/ middle school nurse daily until cleared by a physician. Once cleared by a physician, athletes will be required to complete a progressive return-to-activity protocol, and parents will be required to sign a UIL Concussion Management Protocol Return to Play

Form. Please keep in mind, that even if an athlete is cleared by a physician, he or she may not pass the progressive return-to-play protocol.

## **Return-To-Play Considerations**

*CFISD is proactive in the prevention, recognition, and management of concussions in order to limit the risk of concussions associated with athletics, as well as to limit the potential catastrophic and long-term risks associated with sustaining a concussion. Therefore, the management and return-to-play decisions will remain in the realm of clinical judgment on an individual basis by both the campus athletic trainer/middle school coach and the athlete's physician.*

CFISD protocol following a head injury follows a stepwise progression. The athlete should be released from a physician, have a signed UIL approved return to play parent/ athlete consent form, and be symptom free for 24 hours before beginning this progression. The athlete should complete each level and progress to the next (in 24 hour intervals) if they remain asymptomatic both at rest and with exercise. Should the athlete become symptomatic during the progression, they should drop back to the previous asymptomatic level and try again to progress after a 24-hour period of rest has passed. If the athlete remains symptomatic for an extended period of time the athlete may need to return to the physician.

**Level 1- Light aerobic exercise- 5 to 10 minutes on an exercise bike or light jog; no weight lifting, resistance training, or any other exercise.**

**Level 2- Moderate aerobic exercise- 15-20 minutes of running at moderate intensity in the gym or on the field without a helmet or other equipment.**

**Level 3- Non- contact training drills in full uniform. May begin weight lifting, resistance training, and other exercises.**

**Level 4- Full contact practice or training.**

**Level 5- Full game play.**

Continued post-concussive symptoms, prior concussion history and any diagnostic testing results along with neurocognitive testing and physical exam, will be utilized by the athlete's physician and campus athletic trainer/middle school coach in establishing a timeline for an athlete's return to activity. It is important to note that this timeline could last over a period of days, weeks, months, or potentially medically disqualify the student from athletics. All cases will be handled on an individual basis.

## **Head Injury Data**

Within seven days of a head injury occurring or being cleared, all information will be reported to the Concussion Oversight Team. A standardized reporting form will be utilized for reporting purposes.

- High School Athletic Trainers will report to the Concussion Oversight Team
- Middle School Coaches will report to the Safety Coordinator who will in turn report to the Concussion Oversight Team
- Safety Coordinator will follow-up with Middle School Coaches on all head injuries

## **Liability Provisions**

The creation of this policy and procedures handbook does not, in any way:

- Waive statutory or common law immunity from liability of CFISD, or of its officers or employees;
- Create liability for a cause of action against CFISD or against its officers or employees; Waive immunity from liability under Section 74.151, Civil Practice and Remedies Code; or
- Create liability for a member of a concussion oversight team arising from the injury or death of a student participating in an interscholastic athletics practice of competition, based solely on service on the concussion oversight team.

# Concussion Management Card

**CFISD**

**Concussion Management Card**



## Possible Signs and Symptoms Evaluation

### Signs Observed by Staff

- 1) appears to be dazed or stunned
- 2) is confused about assignment
  - 3) forgets plays
- 4) is unsure of game, score, or opponent
  - 5) moves clumsily
- 6) answers questions slowly
- 7) loses consciousness (even temporarily)
- 8) shows behavior or personality change
- 9) forgets events prior to hit (retrograde)
- 10) forgets events after hit (anterograde)

### Symptoms Reported by Athlete

1. headache
  - nausea
  - balance problems or dizziness
  - double or fuzzy vision
  - sensitivity to light or noise
  - feeling sluggish
  - feeling "foggy"
  - change in sleep pattern
  - concentration or memory problems

**Symptoms may worsen with exertion or become present over time. Any failure should be considered abnormal.**

## On-Field Cognitive Testing

### Orientation

1. When did the headache start?
2. What stadium/school is this?
3. Who is the opposing team?
4. What month is it?
5. What day is it?

### Anterograde Amnesia

Ask the athlete to repeat three words.

Ex. Girl, Dog, Green      Ex. Ball, Red, School

### Retrograde Amnesia

Ask the athlete the following questions.

1. Do you remember what happened?
2. When was the last time you ate?
3. What did you have to eat last?
4. What quarter/period are we in?
5. What is the score of the game?

### Concentration

Ask the athlete to do the following.

1. Repeat the days of the week backward (starting with today).
2. Repeat series of numbers backward:  
Ex. 419 (914 is correct)      6385 (5836 is correct)

### Word List Memory

Ask the athlete to repeat the three words from earlier

Ex. Girl, Dog, Green      Ex. Ball, Red, School

**Any failure should be considered abnormal. Consult a physician following a suspected concussion.**



# Cypress-Fairbanks Independent School District

## Head Injury Notification & Physician Clearance for Return to Play (RTP) Protocol

Student name/ID: \_\_\_\_\_ / \_\_\_\_\_ Sport: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/20\_\_

Head injury was:  Observed by CFISD staff  Reported by student during school sponsored practice/game  
 Reported by student/parent occurring on \_\_\_\_/\_\_\_\_/\_\_\_\_ (date) outside of CFISD sponsored activities

<b>HEAD INJURY DESCRIPTION</b>	
<b>OBSERVED SIGNS:</b>	
<input type="checkbox"/> Dazed/stunned	<input type="checkbox"/> Confused
<input type="checkbox"/> Loss of Consciousness	<input type="checkbox"/> Slow speech
<input type="checkbox"/> Clumsy movements	<input type="checkbox"/> Unusual Behavior
<input type="checkbox"/> Cannot recall events prior to hit	
<input type="checkbox"/> Cannot recall events after hit	
<input type="checkbox"/> Other: _____	
<b>SELF-REPORTED SIGNS:</b>	
<input type="checkbox"/> Headache	<input type="checkbox"/> Nausea
<input type="checkbox"/> Loss of balance	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Disrupted sleep	<input type="checkbox"/> Loss of memory
<input type="checkbox"/> Inability to concentrate/focus	
<input type="checkbox"/> Other: _____	
<b>OBTAIN EMERGENCY CARE IF:</b>	
<input checked="" type="checkbox"/> ↑ confusion/agitation	<input checked="" type="checkbox"/> Slurred Speech
<input checked="" type="checkbox"/> Symptoms worsen	<input checked="" type="checkbox"/> Seizure
<input checked="" type="checkbox"/> Extreme drowsiness/cannot be awakened	

<b>RETURN TO PLAY PROTOCOL</b>
<p>In accordance with CFISD Board policy FM (LEGAL) and Texas Education Code Sec. 38.151-160, any student athlete must be removed from UIL practice/play if a coach, physician, licensed healthcare provider, or parent/guardian believes the student athlete may have sustained a concussion. After physician clearance, the athlete must complete the CFISD RTP protocol outlined below before returning to UIL practice/play.</p> <ul style="list-style-type: none"> <li>Level 1: Light aerobic exercise (5-10 min. w/o resistance training)</li> <li>Level 2: Moderate aerobic exercise (15-20 min. mod. intensity run)</li> <li>Level 3: Non-contact drills (full uniform with resistance training)</li> <li>Level 4: Full contact practice/training</li> <li>Level 5: Full game play</li> </ul> <p>Any athlete report (or CFISD employee observation) of head injury symptoms stops the RTP protocol, and the athlete must wait 24 hours before repeating the protocol level that induced symptoms.</p>

\_\_\_\_\_  
 Printed name CFISD HCP/coach      Signature CFISD HCP/coach      (\_\_\_\_) \_\_\_\_ - \_\_\_\_ / \_\_\_\_ /20\_\_  
 Phone number      Date

\_\_\_\_\_  
 Printed name, parent/guardian      Signature parent/guardian      (\_\_\_\_) \_\_\_\_ - \_\_\_\_ / \_\_\_\_ /20\_\_  
 Phone number      Date

<b>PHYSICIAN RELEASE</b>			
<b>(Completed by treating physician only. APRN, PA, and DC are not acceptable according to Texas Education Code)</b>			
<p><b>Physicians:</b> In order for a student athlete to return to UIL competition, he/she must be evaluated, using established medical protocols based on peer-reviewed scientific evidence, by a <b>treating physician</b>. If applicable, please attach a detailed description of your recommended classroom accommodations to this form. CFISD will discontinue classroom accommodations upon the athlete's successful completion of Level 4 of the RTP unless otherwise specified in your communication. In your professional opinion:</p>			
<p><input type="checkbox"/> Athlete <b>IS CLEARED</b> to participate in the RTP protocol beginning on ____/____/20__, requires no classroom accommodations, and should return to full athletic practice/play upon completion of RTP.</p> <p><input type="checkbox"/> Athlete <b>IS CLEARED</b> to participate in the RTP protocol beginning on ____/____/20__, requires no classroom accommodations, and <b>must be reevaluated</b> by me before return to full athletic practice/play.</p> <p><input type="checkbox"/> Athlete <b>IS NOT CLEARED</b> for the RTP and will be reevaluated on ____/____/20__.</p> <p><input type="checkbox"/> Other (i.e. cleared with recommended classroom accommodations): _____</p>			
<p>_____            Printed name, Physician      Signature and credentials      (____) ____ - ____ / ____ /20__            Phone number      Date</p>			



# Cypress-Fairbanks Independent School District

## Concussion Oversight Team: Middle School Head Injury Return-to-Play (RTP) Checklist

Student name/ID: \_\_\_\_\_ / \_\_\_\_\_ Campus: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/20\_\_\_\_

**Before initiating the RTP protocol**, ensure all documents listed below have been supplied/received as appropriate.

<input type="checkbox"/> Date of Injury	Date: ____/____/20____
<input type="checkbox"/> Completed <i>Injury Report</i> (uploaded to Rank One or sent to Safety Coordinator)	Date: ____/____/20____
<input type="checkbox"/> Provided Parent/Guardian <i>Head Injury Notification &amp; Physician Clearance for RTP Protocol</i> form (pink copy retained by CFISD staff/white and yellow copy sent with parent for <b>physician</b> completion)	Date: ____/____/20____
<input type="checkbox"/> Nurse Notified (if protocol not initiated by nurse)	Date: ____/____/20____
<input type="checkbox"/> Date of <b>Physician</b> evaluation	Date: ____/____/20____
<input type="checkbox"/> Conditional release received (follow-up w/ <b>physician</b> required)	N/A or Date: ____/____/20____
<input type="checkbox"/> Unconditional release (no follow-up required)	Date: ____/____/20____

**Upon submission/receipt of all documents listed above**, proceed to Level 1 assessment. Any athlete report (or CFISD employee observation) of head injury symptoms stops the RTP protocol, and the athlete must wait 24 hours before repeating the protocol level that induced symptoms.

Level 1: Light aerobic exercise: 5-10 minutes exercise bike or light jog. No weightlifting, resistance training or other exercise.

<input type="checkbox"/> Athlete completes level w/o symptoms	Supervisor Initials: _____	Date: ____/____/20____	
<input type="checkbox"/> HCP asymptomatic assessment	HCP Initials: _____	Date: ____/____/20____	<b>Completed Level 1</b>

Level 2: Moderate aerobic exercise: 15-20 minutes moderate intensity running (gym or field) without a helmet or other equipment.

<input type="checkbox"/> Athlete completes level w/o symptoms	Supervisor Initials: _____	Date: ____/____/20____	
<input type="checkbox"/> HCP asymptomatic assessment	HCP Initials: _____	Date: ____/____/20____	<b>Completed Level 2</b>

Level 3: Non-contact training drills in full uniform. May begin weightlifting, resistance training and other exercise.

<input type="checkbox"/> Athlete completes level w/o symptoms	Supervisor Initials: _____	Date: ____/____/20____	
<input type="checkbox"/> HCP asymptomatic assessment	HCP Initials: _____	Date: ____/____/20____	<b>Completed Level 3</b>

Level 4: Full contact practice or training.

<input type="checkbox"/> Athlete completes level w/o symptoms	Supervisor Initials: _____	Date: ____/____/20____	
<input type="checkbox"/> HCP asymptomatic assessment	HCP Initials: _____	Date: ____/____/20____	<b>Completed Level 4</b>

**Stop RTP and complete document as described below.**

<input type="checkbox"/> CFISD HCP completes top portion of <i>UIL RTP Consent Form</i>	Date: ____/____/20____
<input type="checkbox"/> Parent/Guardian completes bottom portion of <i>UIL RTP Consent Form</i>	Date: ____/____/20____

**Upon receipt of the UIL RTP Consent Form (all boxes checked and signed by P/G)**, proceed to Level 5 assessment.

Level 5: Full game play.

<input type="checkbox"/> Athlete completes level w/o symptoms	Supervisor Initials: _____	Date: ____/____/20____	
<input type="checkbox"/> HCP asymptomatic assessment	HCP Initials: _____	Date: ____/____/20____	<b>Completed Level 5</b>

HCP printed name: _____	Supervisor printed name: _____
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White: CFISD HCP

Yellow: Coach/Student Athletic File

Pink: Concussion Oversight Team

Revised 8/2019



# Cypress Fairbanks Independent School District High School Head Injury Return to Play Check List

_____	_____	_____
Student Name	Date of Injury	Campus
_____	_____	
Student ID #	Sport	

<input type="checkbox"/>	Parent Notified	Date: _____
<input type="checkbox"/>	Nurse Notified	Date: _____
<input type="checkbox"/>	Athlete Seen by Physician	Date: _____
<input type="checkbox"/>	Unconditional Release by Physician	Date: _____
<input type="checkbox"/>	Conditional Release by Physician	Date: _____

*The athlete may only progress to the next level of the RTP protocol if he/she does not report or exhibit symptoms for 24 hours after the RTP activity.*

**Level 1-** Light aerobic exercise- 5 to 10 minutes on an exercise bike or light jog; no weight lifting, resistance training, or any other exercise.

Date Completed: \_\_\_\_\_ Supervised By: \_\_\_\_\_

**Level 2-** Moderate aerobic exercise- 15-20 minutes of running at moderate intensity in the gym or on the field without a helmet or other equipment.

Date Completed: \_\_\_\_\_ Supervised By: \_\_\_\_\_

**Level 3-** Non-contact training drills in full uniform. May begin weight lifting, resistance training, and other exercises.

Date Completed: \_\_\_\_\_ Supervised By: \_\_\_\_\_

**Level 4-** Full contact practice or training.

Date Completed: \_\_\_\_\_ Supervised By: \_\_\_\_\_

## **UIL Concussion Management Protocol Return to Play form**

Date Provided: \_\_\_\_\_ Date Returned: \_\_\_\_\_

**Level 5-** Full game play

Date Completed: \_\_\_\_\_ Supervised By: \_\_\_\_\_

**Date RTP Check List Form Completed:** \_\_\_\_\_ **Received by:** \_\_\_\_\_

# Concussion Return to



# Management Protocol Play Form

*This form must be completed and submitted to the athletic trainer or other person (who is not a coach) responsible for compliance with the Return to Play protocol established by the school district Concussion Oversight Team, as determined by the superintendent or their designee (see Section 38.157 (c) of the Texas Education Code).*

\_\_\_\_\_  
Student Name (Please Print)

\_\_\_\_\_  
School Name (Please Print)

## Designated school district official verifies:

Please Check

- The student has been evaluated by a treating physician selected by the student, their parent or other person with legal authority to make medical decisions for the student.
- The student has completed the Return to Play protocol established by the school district Concussion Oversight Team.
- The school has received a written statement from the treating physician indicating, that in the physician's professional judgement, it is safe for the student to return to play.

\_\_\_\_\_  
School Individual Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
School Individual Name (Please Print)

## Parent or other person with legal authority to make medical decisions for the student signs and certifies that he/she:

Please Check

- Has been informed concerning and consents to the student participating in returning to play in accordance with the return to play protocol established by the Concussion Oversight Team.
- Understands the risks associated with the student returning to play and will comply with any ongoing requirements in the return to play protocol.
- Consents to the disclosure to appropriate persons, consistent with the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191), of the treating physician's written statement under Subdivision (3) and, if any, the return to play recommendations of the treating physician.
- Understands the immunity provisions under Section 38.159 of the Texas Education Code.

\_\_\_\_\_  
*Parent/Responsible Decision-Maker Signature*

\_\_\_\_\_  
*Date*

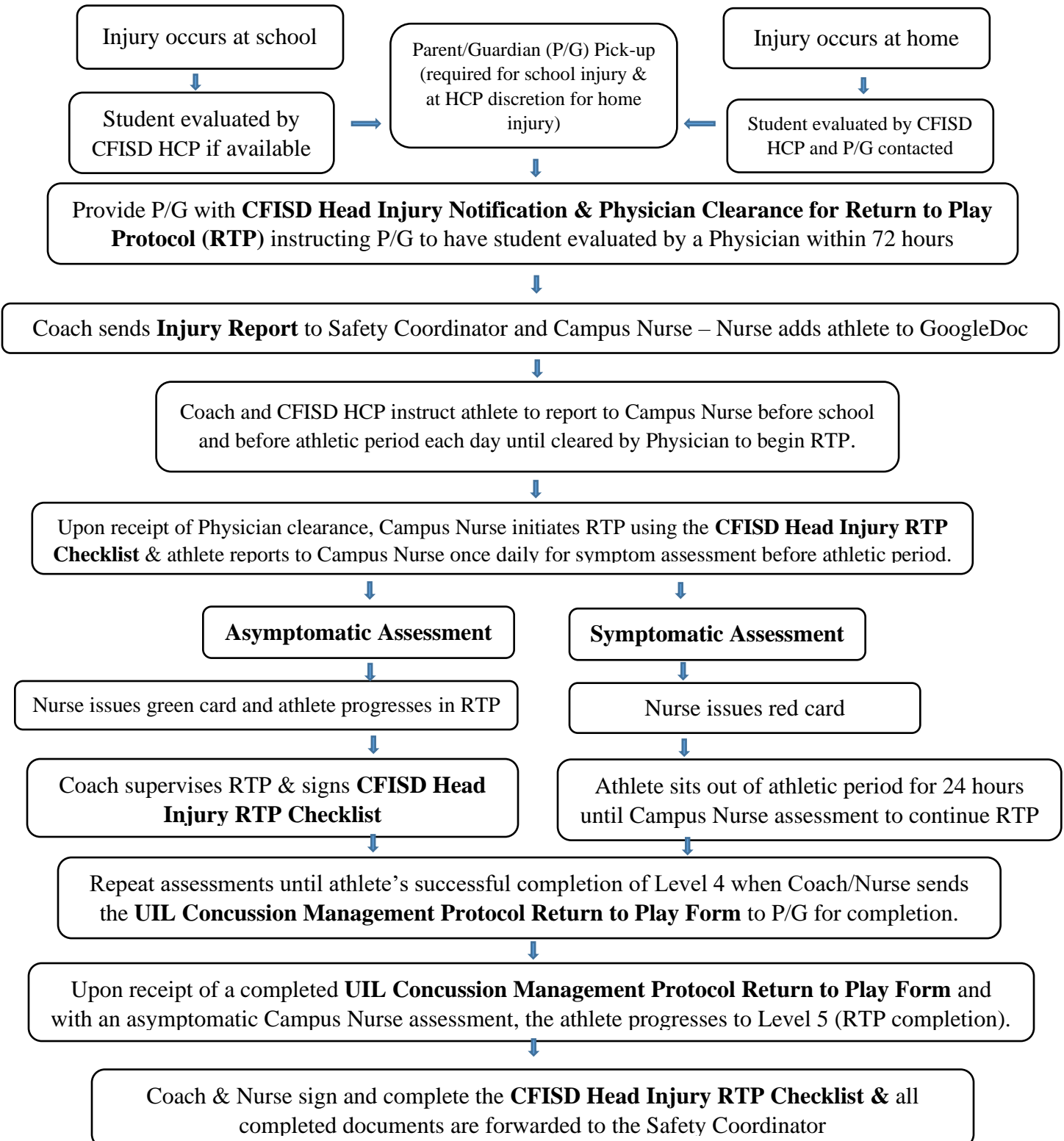
\_\_\_\_\_  
*Parent/Responsible Decision-Maker Name (Please Print)*



# Cypress-Fairbanks Independent School District

## Middle School Return to Play (RTP) Management Protocol

Traumatic Force head injuries (head to head contact, falling and hitting ground, etc.) exhibiting unconsciousness or any concussion-like symptoms must be reported to the coach or CFISD health care professional (HCP) immediately. Nurses and Coaches must communicate regularly to ensure compliance with RTP expectations.



# **Concussions**

**(Texas Education Code Sec. 38. 151-160)**

Report All Head Injuries

Remove from Activity Immediately

Parent/ Guardian Contact

Physician Release

Parent/ Athlete Release

Progressive Return to Play Protocol

- 1) Light Aerobic
- 2) Moderate Aerobic
- 3) Non-Contact Practice
- 4) Full Contact Practice
- 5) Full Game