Concussion Take Home Information

You are receiving this packet because your child is suspected of having a concussion. If you have any questions or concerns, please contact the athletic trainer, Alexis Cohen, via email at acohen@floridaufsd.org. You MUST get a note from the doctor to return to athletics whether there is a concussion diagnosis or not! PLEASE ALSO HAVE YOUR DOCTOR FILL OUT THE FORM IN THIS PACKET TITLED "PHYSICIAN COMMUNICATION DOCUMENTATION."

Emergency Referral:

Call your doctor or go to the emergency room if:
- Concussion symptoms are getting worse
- There is a loss of consciousness
- Weakness or numbness in arms or legs
- Seizure
- Slurred speech
- Vomiting

At Home Do's and Don'ts:

It is OK to:	NO need to:	DO NOT:
Ice pack to head/neck	Check eyes with light	Take pain relievers*
Eat normally	Wake up every hour	Exercise
Return to school	Test reflexes	Rough-house
Go to sleep	Stay in bed	Drink alcohol
Rest		

*Pain relievers mask concussion symptoms. Monitoring symptoms is critical to determining the severity of injury. For permission to take medication, please consult your physician.

Cognitive Rest: You should avoid excess stimulation while symptomatic (TV, video games, computer, loud music, excessive reading, texting).

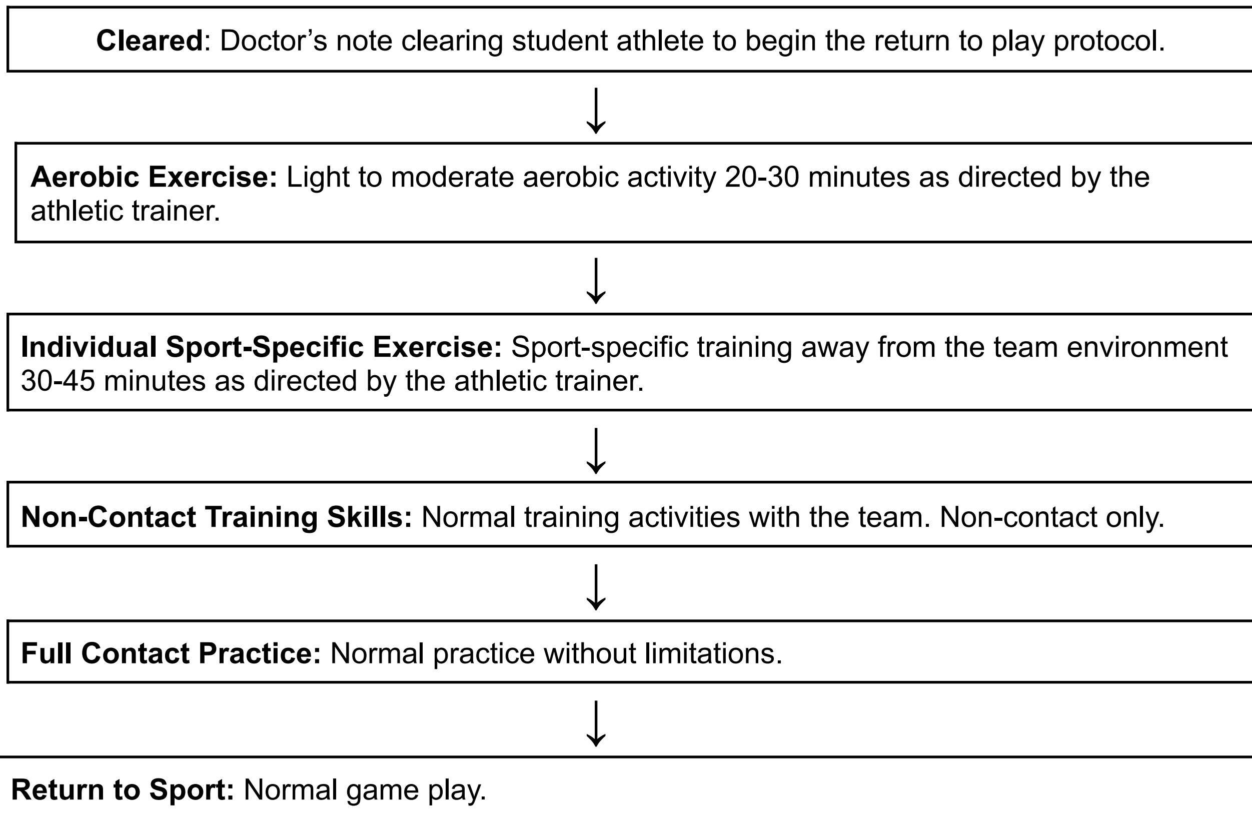
Scan QR codes for additional information and resources:

CDC Heads Up Concussion S/S

NYSED Concussion Guidelines for Schools 2023

Return to Sport Flowsheet

If your student athlete is diagnosed with a concussion, they MUST complete the return to play protocol before they may return to athletics. In order to progress to the next stage of the protocol, the athlete must remain symptom-free for 24 hours. The athletic trainer will complete the return to play for student athletes.



Once the 5-day return to play protocol is completed, it will be sent to the district medical director to get signed off on. Until we receive it signed, the student athlete will continue to do Day 5 of the protocol.

If you have any questions regarding this protocol, please feel free to contact the athletic trainer.

Alexis Cohen, ATC
acohen@floridaufsd.org
845-651-3095 Ext. 30114

Florida Union Free School District
Physician Communication Documentation

THIS MUST BE SIGNED AND RETURNED BY PHYSICIAN PRIOR TO PROGRESSING TO TEAM SETTING OF RETURN-TO-SPORT PROTOCOL

Name:____Age:______Sport:__________________
Date of Incident:__________________________Date of Appointment:_______________________

Signs/Symptoms present during visit:
____
____
Additional Findings/Concerns:____

Academic Accommodations: ☐ No accommodations needed at this time.
Attendance: ☐ No school for ___ days ☐ Provide tutoring at home/school if needed ☐ Half Days ☐ Shortened Days ___ hours ☐ Shortened Classes _____ minutes
Breaks: ☐ Allow rest break in nurses office if symptoms increase ☐ Allow early dismissal if symptoms don't subside with rest.
Extra Time: ☐ Allow extra time to complete assignments/tests ☐ Take rest breaks as needed
Homework: ☐ Lessen homework by ___%, or ___ minutes/class, or max of ____ mins nightly
Testing: ☐ No significant testing at this time ☐ Limited testing ______ ☐ Provide alternate setting
Vision: ☐ Lesson screen time to max of ___ mins/day and no more than ___ continuous mins ☐ Allow sunglasses/hat ☐ Print class notes to size 14 font
Environment: ☐ Alternative setting during band/music/chorus ☐ Alternative setting during PE/Recess/Cafeteria ☐ Allow early class release to avoid loud hallways ☐ Allow earplugs in noisy environment ☐ Should not attend athletics practice or limit attendance to ___ mins
Academic accommodations expire when athlete completes the RTP protocol

Return to Sport:
☐ Athlete **DOES NOT HAVE A CONCUSSION** and can return directly to athletics
☐ Athlete is **asymptomatic** and can continue to progress through the RTP protocol
☐ Athlete is **symptomatic and being held** from all activity
☐ Athlete is currently symptomatic, but **can begin RTP protocol when symptoms resolve**

Acknowledgements:
☐ I have been shown the athlete's initial evaluation form/symptom score sheet.
☐ I understand that the athlete's progress in reference to the NYS Mandated Return to Sport Protocol.

Signature:____Date:____________
Printed name/stamp of medical provider:____

Florida Union Free School District
Concussion Checklist and Evaluation Form

Name:_______________________________________ Age:___________ Grade:__________
Date of Injury:________________________________ Sport:__________________________

On-Site Evaluation:

____
____
____

Has the athlete ever had a concussion?	Yes	No	If Yes, how many?______________
Was there a loss of consciousness?	Yes	No	Unclear
Does he/she remember the injury?	Yes	No	Unclear
Does he/she have confusion after injury?	Yes	No	Unclear

Symptoms observed at time of injury:

Dizziness	Yes	No	Headache	Yes	No
Ringing in ears	Yes	No	Nausea/vomiting	Yes	No
Drowsy/sleepy	Yes	No	Fatigue/Low Energy	Yes	No
“Don’t feel right”	Yes	No	Feeling “dazed”	Yes	No
Seizure	Yes	No	Poor balance/coord.	Yes	No
Memory Problems	Yes	No	Loss of Orientation	Yes	No
Blurred vision	Yes	No	Sensitivity to Light	Yes	No
Vacant Stare	Yes	No	Irritability	Yes	No
Tinnitus	Yes	No	Emotional	Yes	No

Other findings/comments:

____
____
____

Final Action Taken:

☐ Parents Notified ☐ Referred to Primary Care ☐ Sent to Hospital

Evaluator’s Signature:_____________________________________ Title:________________
Date:_____________________ Phone: ____________________