

PHYSICIAN HEAD INJURY EVALUATION FORM

Rutgers Preparatory School Athletic Training
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Date: _____

Dear Physician:

_____ has sustained a suspected head injury while participating in _____ at Rutgers Preparatory School and has been referred to you for evaluation.

Rutgers Preparatory School follows the concussion guidelines set forth by the Zurich Concussion Consensus Statement and the NJSIAA as follows:

Return to Play Guidelines

First time concussed athletes with no loss of consciousness and signs/symptoms lasting less than 7 days may return to play when he/she meets the following criteria:

1. Asymptomatic (with no use of medications to mask headache or other symptoms).
2. Completes the Zurich Activity Progression (see below) once asymptomatic for 24 hours and medically cleared by a physician to do so.
3. ImPACT scores return to within normal limits of baseline (*if applicable*). Athletes who participate in soccer, basketball, wrestling, baseball, softball and lacrosse are required to take an ImPACT neurocognitive baseline test. Other sports may take the baseline on a voluntary basis.

Any loss of consciousness (>1min), signs/symptoms lasting 7 days or longer, or repeat concussions will require a minimum 7 day asymptomatic period and medical clearance before beginning the Zurich Activity Progression and will be managed on an individualized basis as approved by the supervising physician. The asymptomatic period for any concussion may be extended at the discretion of the Athletic Trainer.

Athletes who hand in physician clearance notes inconsistent with this policy may be asked to seek a second opinion.

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Zurich Return to Activity Progression

We follow a stepwise activity progression based on recommendations in the Zurich Consensus Statement from the 3rd International Congress on Concussion in Sport¹ as follows:

- Step 1: Light aerobic exercise (ie: stationary bike, elliptical machine)
- Step 2: Moderate aerobic exercises (begin running program)
- Step 3: Functional exercises (increase running intensity, begin agilities, non-contact sport-specific drills)
- Step 4: Non-contact practice activities
- Step 5: Full contact practice activities
- Step 6: Full game play

Each step is separated by 24 hours. If any symptoms occur, the athlete will drop back to the previous level and try to progress again after 24 hours of rest has passed.

ImPACT Testing

In the sports of soccer, basketball, wrestling, baseball, softball and lacrosse we require pre-season baseline and post-concussion neurocognitive testing using the ImPACT® (Immediate Post Concussion Assessment and Cognitive Testing) software program to assist in the management of head injuries. The 20-minute program is set up in a “video-game” format. It tracks neurocognitive information such as memory, reaction time, brain processing speed and concentration. We conduct a post-concussive test when the athlete is asymptomatic and continue to test the athlete until their scores return to normal. Please note that this program is used only as a tool in making return to play decisions. Additional information about ImPACT® can be found at www.impacttest.com.

Thank you for your assistance. If you have any questions, please feel free to contact us.

Sincerely,

Tim Seminerio, ATC
Susan Paterson, ATC
Certified Athletic Trainer

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For the Physician: Please indicate your diagnosis and treatment plan below. Thank you.

Athlete's Name: _____

Date: _____

Physician's Diagnosis: _____

Return to Activity

Please check one:

I agree the athlete is cleared for unrestricted sports once he/she meets the criteria outlined in this policy. This includes:

1. Asymptomatic (with no use of medications to mask headache or other symptoms).
2. Completion of Zurich Activity Progression. This may begin once the athlete is asymptomatic for 24 hours.
3. ImPACT scores return to within normal limits of baseline (*if applicable*).

I have different recommendations beyond the above recommendations (please specify).

The athlete is to see me again before beginning any physical activity.

Additional comments:

I hereby certify that I have received training in the evaluation and management of concussions. (N.J.S.A. 18a:40-41, 4)

Signature of physician _____ MD, DO
(circle one)

Printed name of physician:

Office address of physician:

Telephone

No: _____

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**Please return this form to the Athletic Training
Office**