

**CONCUSSION PROTOCOL OVERVIEW**

1. We are committed to the health and well-being of our student athletes.
2. Staff will promote an environment in which reporting symptoms of a concussion is considered acceptable.
3. Our Physical Education Teachers, Coaches, Nurses and Athletic Director will receive approved/required training in recognizing the signs/symptoms and behaviors consistent with concussion injuries.
4. All students receiving such an injury will be removed from play **with no return to play that day.**
5. The parents of all students with suspected head injury/concussion will be advised of the injury and evaluation/monitoring procedure that is recommended unless the student is deemed in distress, which will be an immediate 911 call for emergency transport.
6. The evaluating physician may choose to allow:
  - Return to play/gym AFTER INITIAL 24 HOUR PERIOD
  - Initiate return to play per zurich progressive exertion protocol
  - Continue evaluation and treatment of student athlete until medically cleared
7. If suspected concussion or concussion is diagnosed then, Dr. Carl Sgambati (the school physician), the student's primary care physician or neurologist must clear all students before return to play procedures can begin.
8. Concussion management team (Medical Director, Athletic Director, School Nurse, student's Coach and student's Guidance Counselor) will follow student progress from injury thru return to play with final disposition after 14 days of return to play.
9. The concussion file may be reactivated at any time due to questions or concerns regarding student athlete's status.
10. Once per year an in-service for all staff will be given.
11. All members of the Concussion Management Team (CMT) will be available on an on going basis for consultation or clarification.
12. All protocols/guidelines/care plans will be in accordance with guidelines approved by NYSED, NYSPHAA, CDC. Guidelines may be reviewed at their respective web sites, see attached resource page.

MECHANICVILLE CITY SCHOOL DISTRICT

**Concussion Protocol**

PLEASE READ THE CONCUSSION PROTOCOL BEFORE SIGNING

I, the undersigned, have received the attached concussion protocol and clearly understand the inherent risks associated with the participation in physical education and athletic competition. I, the undersigned, clearly understand the procedures put forth by the district to protect the student/athlete. I will accept the district's designated medical directors evaluation determining when or if the student/athlete may resume physical education and/or athletic participation.

**Student Name:** \_\_\_\_\_ **Grade:** \_\_\_\_\_

**Signed:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
**(Parent/Guardian Signature)**

**MUST BE RETURNED TO THE SCHOOL HEALTH OFFICE**