ATHLETIC CONCUSSION POLICY

The purpose of this policy is to provide information and standardized procedures for persons involved in the prevention, training management and return to activity decisions regarding students who incur head injuries while involved in extracurricular athletic activities\(^1\) including, but not limited to, interscholastic sports, in order to protect their health and safety as required by Massachusetts law and regulations. The requirements of the law apply to all public middle and high schools, however configured, serving grades six through high school graduation. In addition to any training required by law, the following persons shall complete one of the head injury safety training programs approved by the Massachusetts Department of Public Health (DPH) as found on its website: coaches; certified athletic trainers; trainers; volunteers; school and team physicians; school nurses; athletic directors; directors responsible for a school marching band; employees or volunteers; and students who participate in an extracurricular activity and their parents.

Upon the adoption of this policy by the School Committee, the Superintendent shall ensure that DPH receives an affirmation on school district letterhead that the district has developed policies and the School Committee has adopted a final policy in accordance with law. This affirmation shall be updated by September 30, 2013 and every two years thereafter upon review or revision of its policies.

The Superintendent shall maintain or cause to be maintained complete and accurate records of the district’s compliance with the requirements of the Concussion Law, and shall maintain the following records for three years or, at a minimum, until the student graduates, unless state or federal law requires a longer retention period:

1. Verifications of completion of annual training and receipt of materials;
2. DPH Pre-participation forms and receipt of materials or school-based equivalents;
3. DPH Report of Head Injury Forms, or school based equivalents;
4. DPH Medical Clearance and Authorization Forms, or school based equivalents; and
5. Graduated reentry plans for return to full academic and extracurricular athletic activities.

This policy also applies to volunteers who assist with extracurricular athletic activities. Such volunteers shall not be liable for civil damages arising out of any act or omission relating to the

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\(^1\) Extracurricular Athletic Activity means an organized school sponsored athletic activity generally occurring outside of school instructional hours under the direction of a coach, athletic director or marching band leader including, but not limited to, Alpine and Nordic skiing and snowboarding, baseball, basketball, cheer leading, cross country track, fencing, field hockey, football, golf, gymnastics, horseback riding, ice hockey, lacrosse, marching band, rifle, rugby, soccer, skating, softball, squash, swimming and diving, tennis, track (indoor and outdoor), ultimate frisbee, volleyball, water polo, and wrestling. All interscholastic athletics are deemed to be extracurricular athletic activities.

Massachusetts Association of School Committees - 2011
requirements of law, unless such volunteer is willfully or intentionally negligent in his act or omission.

Most student athletes who sustain a concussion can fully recover as long as their brain has time to heal; however, relying only on an athlete’s self-report of symptoms to determine injury recovery is inadequate as many high school athletes are not aware of the signs and symptoms or the severity concussive injuries pose, or they may feel pressure from coaches, parents, and/or teammates to return to play as quickly as possible. One or more of these factors will likely result in under-diagnosing the injury and a premature return to play. Massachusetts General Laws and Department of Public Health regulations make it imperative to accurately assess and treat student athletes when concussions are suspected.

Student athletes who receive concussions may appear to be “fine” on the outside, when in actuality they have a brain injury and are not able to return to play. Incurring a second concussion can prove to be devastating to a student athlete. Research has shown that young concussed athletes who return to play before their brain has healed are highly vulnerable to more prolonged post-concussion syndrome or, in rare cases, a catastrophic neurological injury known as Second Impact Syndrome.

The following protocol will discuss and outline what a concussion is, the mechanism of injury, signs and symptoms, management and return to play requirements, as well as information on Second Impact Syndrome and past concussion syndrome. Lastly, this policy will discuss the importance of education for our athletes, coaches and parents and other persons required by law.

This protocol should be reviewed on a yearly basis with all staff to discuss the procedures to be followed to manage sports-related concussions. This protocol will also be reviewed on a yearly basis by the athletic department as well as by nursing staff. Any changes in this document will be approved by the school committee and given to athletic staff, including coaches and other school personnel in writing. An accurate synopsis of this policy shall be placed in the student and faculty handbooks.

LEGAL REFS: M.G.L. 111:222; 105 CMR 201.000
105 CMR 201.000: Head Injuries and Concussions In Extracurricular Athletic Activities

Year End Reporting Form for Schools, 2014-2015

This is a two page form.

Instructions for completing this form and other frequently asked questions begin on page 3.

This form should be completed and returned via email to DPH-ConcussionPolicies@MassMail.State.MA.US
Or mailed in hard copy to: Linda Brown, Division of Violence and Injury Prevention,
4th Floor, Massachusetts Department of Public Health; 250 Washington Street; Boston, MA 02108
Due by August 31, 2015

PLEASE ONLY SEND ONE FORM PER SCHOOL

Person Completing this Form, Name: ___________________________ Title: ___________________________

Email: ___________________________________________________________

School District: __________________________________________________

School Name: ____________________________________________________

Grades included in the School (check all that apply): 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐

Required Reporting Information (All counts should be for individual schools and for school year 2014-2015 only):

1) Please indicate the total number of Report of Head Injury Forms received by this school in school year 2014-2015: _______

2) Please indicate whether the Report of Head Injury Forms are required to be submitted to this school only for students participating in extracurricular athletics/school sports or for all students.
   Student Athletes Only ☐
   All Students ☐
   Unknown ☐
3) Please indicate how many Report of Head Injury Forms this school received which indicated that the injury occurred when engaged in school sports:  

**Optional Reporting Information:**

4) Total number of Medical Clearance/Return to Play Forms this school received in school year 2014-2015:  

5) Total school enrollment  
   Middle School:  
   High School:  

**NEW OPTIONAL QUESTIONS:**

6) Does your school have an extracurricular sports program (defined as an organized school sponsored athletic activity generally occurring outside of school instructional hours under the direction of a coach, athletic director or bank leader)?  
   Yes:  
   No:  
    
7) Does your school have Licensed Athletic Trainers (see Data Definitions on p. 3)? If so, how many FTEs?  
   Yes:  
   No:  
   FTEs for Licensed Athletic Trainers:  

If there is any additional information collected by your school on student concussion that you wish to provide, please provide below or attach.
The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
250 Washington Street, Boston, MA 02108-4619

PRE-PARTICIPATION HEAD
INJURY/CONCUSSION REPORTING FORM
FOR EXTRACURRICULAR ACTIVITIES

This form should be completed by the student's parent(s) or legal guardian(s). It must submitted to the Athletic Director, or official designated by the school, prior to the start of each season a student plans to participate in an extracurricular athletic activity.

<table>
<thead>
<tr>
<th>Student's Name</th>
<th>Sex</th>
<th>Date of Birth</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>School</th>
<th>Sport(s)</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Home Address</th>
<th>Telephone</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Has student ever experienced a traumatic head injury (a blow to the head)? Yes_______ No_______

If yes, when? Dates (month/year): ____________________________

Has student ever received medical attention for a head injury? Yes_______ No_______

If yes, when? Dates (month/year): ____________________________

If yes, please describe the circumstances:

Was student diagnosed with a concussion? Yes_______ No_______

If yes, when? Dates (month/year): ____________________________

Duration of Symptoms (such as headache, difficulty concentrating, fatigue) for most recent concussion: ____________________________

Parent/Guardian:
Name: ____________________________ Signature/Date ____________________________
(Please print)

Student Athlete:
Signature/Date ____________________________
THE COMMONWEALTH OF MASSACHUSETTS
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
DEPARTMENT OF PUBLIC HEALTH
250 Washington Street, Boston, MA 02108-4619

REPORT OF HEAD INJURY DURING
SPORTS SEASON

This form is to report head injuries (other than minor cuts or bruises) that occur during a sports season. It should be returned to the athletic director or staff member designated by the school and reviewed by the school nurse.

For Coaches: Please complete this form immediately after the game or practice for head injuries that result in the student being removed from play due to a possible concussion.

For Parents/Guardians: Please complete this form if your child has a head injury outside of school related extracurricular athletic activities.

<table>
<thead>
<tr>
<th>Student's Name</th>
<th>Sex</th>
<th>Date of Birth</th>
<th>Grade</th>
</tr>
</thead>
<tbody>
<tr>
<td>School</td>
<td></td>
<td>Sport(s)</td>
<td></td>
</tr>
<tr>
<td>Home Address</td>
<td></td>
<td>Telephone</td>
<td></td>
</tr>
</tbody>
</table>

Date of injury: _____________________

Did the incident take place during an extracurricular activity? _____ Yes _____ No

If so, where did the incident take place? _______________________________________

Please describe nature and extent of injuries to student:

For Parents/Guardians:
Did the student receive medical attention? yes____ no____
If yes, was a concussion diagnosed? yes____ no____

I HEREBY STATE THAT TO THE BEST OF MY KNOWLEDGE, MY ANSWERS TO THE ABOVE QUESTIONS ARE COMPLETE AND CORRECT.

Please circle one: Coach or Marching Band Director Parent/Guardian

Name of Person Completing Form (please print): _______________________________

Signature ______________________________________ Date ________________
# POST SPORTS-RELATED HEAD INJURY MEDICAL CLEARANCE AND AUTHORIZATION FORM

The student must be completely symptom free at rest, during exertion, and with cognitive activity prior to returning to full participation in extracurricular athletic activities. Do not complete this form until a graduated return to play plan has been completed and the student is found to be symptom free at rest, during exertion and with cognitive activity.

<table>
<thead>
<tr>
<th>Student's Name</th>
<th>Sex</th>
<th>Date of Birth</th>
<th>Grade</th>
</tr>
</thead>
</table>

**Date of injury:** ______________  **Nature and extent of injury:** __________________________

Symptoms following injury (check all that apply):

- [ ] Nausea or vomiting
- [ ] Headaches
- [ ] Dizziness/balance problems
- [ ] Double/blurry vision
- [ ] Feeling sluggish/in a fog*
- [ ] Change in sleep patterns
- [ ] Difficulty concentrating
- [ ] Irritability/emotional ups and downs
- [ ] Light/noise sensitivity
- [ ] Fatigue
- [ ] Memory problems
- [ ] Sad or withdrawn
- [ ] Other

Duration of Symptom(s): ______________  
Diagnosis:  [ ] Concussion  [ ] Other: __________________________

If concussion diagnosed, date student completed graduated return to play plan without recurrent symptoms: ______________

Prior concussions (number, approximate dates): __________________________________________

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**I HEREBY AUTHORIZE THE ABOVE NAMED STUDENT FOR RETURN TO EXTRACURRICULAR ATHLETIC ACTIVITY**

Practitioner signature: __________________________  Date: ______________

Print Name: __________________________

- [ ] Physician  [ ] Licensed Athletic Trainer  [ ] Nurse Practitioner  [ ] Neuropsychologist  [ ] Physician Assistant

License Number: __________________________  Phone number: __________________________

Address: __________________________

Name of Physician providing consultation/coordination/supervision (if not person completing this form; please print): __________________________

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**I ATTEST THAT I HAVE RECEIVED CLINICAL TRAINING IN POST-TRAUMATIC HEAD INJURY ASSESSMENT AND MANAGEMENT APPROVED BY THE DEPARTMENT OF PUBLIC HEALTH* OR HAVE RECEIVED EQUIVALENT TRAINING AS PART OF MY LICENSURE OR CONTINUING EDUCATION.**

Practitioner's initials: ______________

Type of Training:  [ ] CDC on-line clinician training  [ ] Other MDPH approved Clinical Training  [ ] Other

(Describe) __________________________

* MDPH approved Clinical Training options can be found at:  www.mass.gov/dph/sports concussion

This form is not complete without the practitioner’s verification of such training.