Los Angeles Unified School District

Interscholastic Athletics Department

CONCUSSION INJURY REPORT / *REPORTE DE LESIÓN CONTUSIVA*

(Required for LAUSD Athletes Only)

Name of Athlete / *Nombre del deportista:*		**Grade** / *Grado*	**School** / *Escuela:*
Home Phone / *Numero de Telefono:*		**Date of Injury** / *Fecha en que ocurrió la lesión:*	
DOB / *Fecha de Nacimiento:*	**Age** / *Edad:*	**Time of Injury** / *Hora en que se lesionó:*	
Gender / *Género:*		**Location Injury Occurred** / *Lugar donde ocurrió la lesión:*	

Disposition From Location/*Disposición de la Ubicación:*
Time / *Hora* : **Released to PARENT/GUARDIAN** / *Liberado a PADRES/TUTOR LEGAL* ☐ **Private Vehicle** / *Vehiculo Privado* ☐ **EMS** ☐

The following symptoms were present (check ✓) / El día de hoy se presentan los siguientes síntomas (marque con una ✓

PHYSICAL / FISICO	**PHYSICAL** / FISICO	**THINKING** / RAZONAMIENTO	**EMOTIONAL** / EMOCIONAL
☐ **Loss of consciousness** *Perdida del conocimiento*	☐ **Visual problems or Sensitivity to light** *Problemas visuales o Sensibilidad a la luz*	☐ **Problems remembering** *Problemas recordando*	☐ **Irritable** / *Irritabilidad*
☐ **Headaches** *Dolores de cabeza*	☐ **Sensitivity to noise** Sensibilidad al ruido	☐ **Problems concentrating** *Problemas de concentración*	☐ **Sadness** / *Tristeza*
☐ **Nausea / Vomiting** Nausea / Vómito	☐ **Numbness / Tingling** *Adormecimiento / Hormigeo*	☐ **Mentally foggy / Drowsiness** *Mentalmente confuso / Somnolencia*	☐ **Feeling more emotional** *Sientiendose mas sensible*
☐ **Fatigue** / *Fatiga*	☐ **Dizziness** / Mareos **Balance Problems** / *Problemas de equilibrio*	☐ **Feeling more slowed down** *Sientiendose mas lento*	☐ **Nervousness** / *Nerviosismo*

SCHOOL FIRST RESPONDER AT TIME OF INJURY

Name (PRINT):	**Signature:**	**Title:**	**Date:**

PARENT/GUARDIAN:
Your child is suspected of sustaining a concussion or head injury. Quite often, signs and symptoms of a head injury do not appear immediately but can appear hours later. This is a referral for your child to see a licensed healthcare provider (LHP) ASAP. A medical recommendation is required to readmit your child to school and to start Stages 1-5 of the "Return to Play" (RTP) protocol on back of this page. The attending licensed healthcare provider (LHP) MUST complete the information below. *According to state law, students who are suspected of having a concussion must have a graduated "Return to Play" (RTP) protocol of no less than seven days duration under the supervision of a licensed health care provider (LHP)

PADRE/MADRE/TUTOR LEGAL:
Se sospecha que su hijo/a ha sufrido una contusión o lesión en la cabeza. Muy a menudo los signos y síntomas de una lesión en la cabeza no se manifiestan inmediatamente, pero pueden presentarse horas depués. El propósito de este reporte es alertarle sobre las signos y síntomas de una contusión o lesión en la cabeza que esté empeorando. *De acuerdo con ley estatal, si se sospecha que un estudiante ha sufrido una contusión, el estudiante debe seguir el protocolo gradual de observación para "Regresar al Juego" ('Return to Play', por sus siglas en inglés) por una duración de no menos de siete días, bajo la supervisión de un proveedor médico autorizado .Por favor pida a su proveedor medico autorizado que llene la parte al pie de la página y además que apruebe el protocolo para "Regresar al Juego" que se encuentra al reverso de esta hoja.

CONSENT: I, the Parent/Guardian, authorize release of information about concussion and management between LAUSD and my child's health care provider.
***CONSENTIMIENTO: Yo, padre/madre/tutor legal, autorizo a que la información sobre la contusión y su tratamiento sea compartida entre el proveedor médico autorizado de mi hijo/a* y el Distrito Escolar Unificado de Los Angeles.**

Parent Name (Print) / Padre/Madre (*Escriba el nombre en letra de molde*):	**Parent Signature** / *Firma del padre/madre/tutor legal:*	**Date** / Fecha:

TO BE COMPLETED BY EXAMINING CA Licensed Health Care Provider (MD/DO/NP/PA)*

DIAGNOSIS:	**Concussion** ☐ **Yes** ☐ **No**	**Other Diagnosis:**	**Date seen:**

I have reviewed the above history of concussion symptoms;
- ☐ May return to school on________________ ☐ No restrictions
- ☐ Start LAUSD Return to Play (RTP) Protocol Stages 1-5; MUST have a medical clearance to start RTP Protocol Stage 6
- ☐ Allow 5 minute-pass to avoid crowded hallways
- ☐ Additional time to take test, specify amount of time and duration:______________ Alternative test methods, specify ________________________
- ☐ Other accommodations, specify ____
- ☐ I have scheduled a follow-up on ____________(mm/dd/yyyy) to re-examine Student Athlete before the start of RTP Stage 6 (a minimum of 6 days after diagnosis of concussion)

CA Licensed Health Care Provider /Hospital/Urgent Care* (stamp)	**Signature of CA Licensed Health Care Provider:**
Print Name of Supervising Physician if NP, PA:	**Signature of Supervising Physician if NP, PA (not required):**
Address:	**Telephone No:**

***CIF State Bylaw 313**
***El estatuto 313 de la CIF**

August 2024

Los Angeles Unified School District
Concussion Return to Play (RTP) Protocol

Athlete's Name: ____________________ **Date of Injury:** ____________________ **Date of Concussion Diagnosis:** ____________________

As stated by CA state law (AB2127), the following requirements must be met prior to an athlete returning to play/competition: 1) Evaluation by a licensed healthcare provider (LHP)*, 2) Completion of a graduated return to play protocol that is no less than 7 days in duration, and 3) Written medical clearance from an LHP.

Instructions for Return to Play Protocol:

- A certified athletic trainer (ATC), physician, or another identified healthcare provider or concussion monitor (e.g. athletic director, coach) must initial each stage after you successfully pass it.
- You cannot progress more than one stage per day (or longer if instructed by your healthcare provider).
- You should return to a normal school schedule and course load without modifications before completing the return-to-play protocol.
- You should inform your healthcare provider or athletic trainer (if available) and obtain follow-up care if you cannot pass a stage after 3 attempts due to a worsening of concussion symptoms or if you feel uncomfortable at any time during the progression.

Concussion Monitor: __________________________ / __________________________ / __________________________
NAME (please print) POSITION SIGNATURE

You must have written clearance from a licensed healthcare provider to begin and progress through the following Stages as outlined below or as otherwise directed.

Nurse verification of physician Clearance: __________________ __________________ __________
NAME (please print) **SIGNATURE** **DATE**

Date & Initials	Stage	Activity	Exercise Example (Activities should be monitored by a designated adult)	Objective of the Stage
	1	Limited physical activity to allow the brain to rest and recover	• Light physical activity should be encouraged. • Light daily activities (e.g. walking, stretching) • No activities requiring exertion (e.g. weightlifting, jogging, P.E. classes)	• Recovery and reduction/elimination of symptoms
	2	Light aerobic activity	• 10-30 minutes of brisk physical activity (e.g. walking, stationary bike) that does not result in more than mild and brief exacerbation of symptoms**	• Increase heart rate to ≤ 55% of perceived maximum *(max)* exertion (e.g., < 100 beats per min) • Monitor for symptom return
	3	Moderate aerobic activity *(Light resistance training)*	• Increase in exertional activities (e.g., 20-30 minutes of jogging, stationary biking, body weight exercises, etc.) that do not result in more than mild and brief exacerbation of concussion symptoms**.	• Increase heart rate to 55-75% max • exertion (e.g.,100-150 bpm)Monitor for symptom return
	4	Strenuous aerobic activity *(Moderate resistance training)*	• Continued increase in intensity and duration of physical activity (e.g. jogging, stationary bike, interval training, weightlifting) that does not result in more than mild and brief exacerbation of concussion symptoms. ** • 30-45 min running or stationary biking. • Weightlifting ≤ 50% of max weight • May begin to incorporate sport-specific training away from the team environment (e.g. change of direction, ball handling). • No activities that pose a risk for head impact	• Increase heart rate to > 75% max exertion • Prepare for return to sport-specific activities • Monitor for symptom return • DO NOT PROGRESS TO STEP 5 IF THIS STEP CAUSES EXACERBATION OF SYMPTOMS
	5	Non-contact training with sport-specific drills	• Exercise to high intensity, including incorporating more challenging training drills (e.g. multi-player training). Can integrate into a team environment. • No contact with people, padding, or the floor/mat	• Resumption of the usual intensity of exercise, coordination, and thinking activities • DO NOT PROGRESS TO STEP 6 IF THIS STEP CAUSES EXACERBATION OF SYMPTOMS AND RETURN TO STEP 4

Prior to beginning Stage 6, please make sure that written clearance from a licensed healthcare provider* is obtained for return to play.
You must be symptom-free prior to beginning Stage 6

Nurse verification of Clearance for Return to Play Stage 6: __________________ __________________ __________
NAME (please print) **SIGNATURE** **DATE**

Date & Initials	Stage	Activity	Exercise Example	Objective of the Stage
	6	Limited contact practice OR Full unrestricted practice for non-contact sports	• Controlled contact drills allowed (no scrimmaging)	• Increase acceleration, deceleration, and rotational forces. • Restore confidence, assess readiness for return to play. • Monitor for symptom return. • DO NOT PROGRESS IF ANY OF THESE • STEPS CAUSES EXACERBATION OF • SYMPTOMS AND RETURN TO STEP 5
	7	Full contact practice Full unrestricted practice	• Return to normal training, with contact. • Return to normal unrestricted training	

MANDATORY: You must complete at least ONE contact practice before returning to competition, or if non-contact sport, ONE unrestricted practice.
All athletes must complete a full 7-day return to play protocol.

Date & Initials	Stage	Activity	Exercise Example	Objective of the Stage
	8	Return to play (competition)	• Normal gameplay (competitive event)	Return to full sports activity without restrictions

*Licensed health care provider shall mean a physician (MD or DO) or licensed professional under the direct supervision of a physician [Nurse Practitioner (NP), Physician Assistant (PA)] trained in the education and management of concussions. A student-athlete who sustains a concussion or possible concussion must receive an evaluation from a medical professional (MD, DO, NP, or PA), as they may also be experiencing other co-occurring medical conditions (e.g., neck injury, cardiopulmonary complications, focal brain injury, etc.) that a medical provider can best evaluate and rule out.

** Mild and brief exacerbation of symptoms should be limited to no more than a 2-point (out of 10) increase in symptoms severity on a pain scale and be no longer than 1 hour duration of an increase in symptoms (e.g. you have a 3/10 headache when starting the activity but after 20 minutes the headache increases to a 5/10, then you should stop the activity and consider modifying or reducing for next time)