What is a concussion?
A concussion is a brain injury that:
• Is caused by a bump, blow, or jolt to the head.
• Can change the way your brain normally works.
• Can range from mild to severe.
• Can occur during practices or games in any sport.
• Can happen even if you haven’t been knocked out.
• Can be serious even if you’ve just been “dinged” or had your “bell rung.”

How can I prevent a concussion?
It’s different for every sport. But there are steps you can take to protect yourself from concussion.
• Follow your coach’s rules for safety and the rules of the sport.
• Practice good sportsmanship at all times.
• Use the proper sports equipment, including personal protective equipment (such as helmets).
   In order for equipment to protect you, it must be:
   - Appropriate for the game, position, and activity
   - Well maintained
   - Properly fitted
   - Used every time you play

How do I know if I’ve had a concussion?
You can’t see a concussion, but you might notice some of the symptoms right away. Other symptoms can show up days or weeks after the injury. It’s best to see a health care professional if you think you might have a concussion. An undiagnosed concussion can affect your ability to do schoolwork and other everyday activities. It also raises your risk for additional, serious injury.

What are the symptoms of a concussion?
• Nausea (feeling that you might vomit)
• Balance problems or dizziness
• Double or fuzzy vision
• Sensitivity to light or noise
• Headache
• Feeling sluggish
• Feeling foggy or groggy
• Concentration or memory problems (forgetting game plays)
• Confusion

What should I do if I think I have a concussion?
• Tell your coaches and your parents. Never ignore a bump, blow, or jolt to the head. Also, tell your coach if one of your teammates might have a concussion.
• Get a medical check up. A health care professional can tell you if you have had a concussion and when you are OK to return to play.
• Give yourself time to recover. If you have had a concussion, your brain needs time to heal. While your brain is still healing, you are much more likely to have a second concussion. Second or later concussions can cause permanent brain damage, and even death in rare cases. Severe brain injury can change your whole life.

It’s better to miss one game than the whole season.
Chillicothe City Schools Head Injury Protocol

SIDELINE MANAGEMENT OF CONCUSSION

1. Did a concussion take place? Based on mechanism of injury, observation, history and unusual behavior and reactions of the athlete, even without loss of consciousness, assume a concussion has occurred if the head was hit and even the mildest of symptoms occur. (See other page for signs and symptoms). Any athlete who exhibits signs, symptoms or behaviors consistent with a concussion (such as loss of consciousness, headache, dizziness, confusion or balance problems) shall be immediately removed from the contest and shall not return to play until cleared with written authorization by an appropriate health care professional.

2. Does the athlete need immediate referral for emergency care? If confusion, unusual behavior or responsiveness, deteriorating condition, loss of consciousness, or concern about neck and spine injury exist, the athlete should be referred at once for emergency care.

3. If no emergency is apparent, how should the athlete be monitored? Every 5-10 minutes, mental status, attention, balance, behavior, speech and memory should be examined until stable over a few hours. If appropriate medical care is not available, an athlete even with mild symptoms should be sent for medical evaluation.

4. No athlete suspected of having a concussion should return to the same practice or contest, even if symptoms resolve in 15 minutes.

IF NO MEDICAL PERSONNEL ARE ON HAND AND AN INJURED ATHLETE HAS ANY OF THE ABOVE SYMPTOMS, HE OR SHE SHOULD BE SENT FOR APPROPRIATE MEDICAL CARE

SIDELINE DECISION-MAKING

1. No athlete should return to play (RTP) on the same day of concussion.

2. Any athlete removed from play because of a concussion must have medical clearance from an
appropriate health care professional before he or she can resume practice or competition. In Ohio, an "appropriate health care professional" shall be a physician, as authorized under ORC Chapter 4731 and includes both doctors of medicine (M.D.) and doctors of osteopathy (D.O.) and an athletic trainer, licensed under ORC Chapter 4755. No immediate family member should be used to clear an athlete to play. The Association has not adopted any official form to be used by physicians or athletic trainers to authorize return to participation. The school and or the health care professional shall determine the form to be used. Please be advised that once the contest official has removed the player from a contest, the removal shall be noted on the score sheet, if one is used in that sport, and there is no further responsibility of that official to monitor this process. Such monitoring is the responsibility of the coach in conjunction with health care professionals. The written authorization to return to play does not have to be provided to the official but shall be kept on file at the school.

3. Close observation of athlete should continue for a few hours. (Athlete must go home with parent or guardian.)

4. After medical clearance, RTP should follow a step-wise protocol with provisions for delayed RTP based on return of any signs or symptoms.

5. All concussions must be reported to athletic office.

MEDICAL CLEARANCE RTP PROTOCOL

1. Cleared by medical professional

2. No exertional activity until asymptomatic.

3. When the athlete appears clear, begin low-impact activity such as walking, stationary bike, etc.

4. Initiate aerobic activity fundamental to specific sport such as skating or running, and may also begin progressive strength training activities.

5. Begin non-contact skill drills specific to sport such as dribbling, fielding, batting, review hitting technique.

6. Full contact in practice setting.

7. If athlete remains asymptomatic, he or she may return to game/play.

Notes:

A. ATHLETE MUST REMAIN ASYMPTOMATIC TO PROGRESS TO THE NEXT LEVEL.
B. IF SYMPTOMS RECUR, ATHLETE MUST RETURN TO PREVIOUS LEVEL.

C. MEDICAL CHECK SHOULD OCCUR BEFORE CONTACT.

Return to class Protocol
Chillicothe City Schools have a commitment to the student’s safety and well-being. This includes easing students back into learning and social activities within school life.

1. All of the students’ teachers, counselors, administrators and coaches should be aware of the student’s injury and symptoms. If symptoms persist, a temporary Section 504 Plan can be implemented.

2. Accommodations can be made for the student until they are cleared by a medical professional. These accommodations can include, but are not limited to, speech therapy, environmental adaptations, modifications to curriculum, and behavioral strategies.

3. Concussion symptoms may occur with activities that require increased concentration such as computer work, reading or studying. These must be monitored.

4. If any symptoms reappear upon returning to school, the student may need to take rest breaks, only attend school on a part-time basis, be given extra time to complete assignments and tests, or receive other assistance.
Coaches,

Please fill out at the time of head injury and attach medical release from healthcare professional upon athletes return to play. Turn completed form in to the athletic office.

Name of Athlete: ________________________________

Date: _________________________________________

Sport: _________________________________________

Coach: _________________________________________

Location: _______________________________________ 

Time: __________________________________________

Symptoms (check all that apply)

☐ *No Pupil Reaction to Light
☐ *Clear Fluid from Nose and/or ear
☐ *Convulsions
☐ *Loss of consciousness
☐ Severe Headache
☐ Nausea and/or Vomiting
☐ Temporary Loss of Memory
☐ Unequal Pupil Size
☐ Slurred Speech
☐ Dizziness or Loss of Coordination
☐ Ringing in Ears
☐ Blurred or Double Vision
☐ Numbness

NOTE: * = May indicate very serious head injury

Referred to Dr. ___________________________________
Date Released to Play

Coach Signature and date

Parent Signature and date

Coach, Please provide to the Parent or Guardian at the time of head injury
Head injury Sheet

A concussion can be a deceptive injury. The signs and symptoms do not always reveal themselves right away. This athlete may initially show no signs or symptoms but later indicate otherwise. This is why it is extremely important for you to look at the following signs and symptoms:

- Slurred Speech
- Dizziness or Loss of Coordination
- Ringing in Ears
- Nausea and/or Vomiting
- Blurred or Double Vision
- Temporary Loss of Memory
- Convulsions
- *No Pupil Reaction to Light
- *Clear Fluid from Nose and/or Ear
- Severe Headache
- Numbness
- Unequal Pupil Size

NOTE: * = May indicate very serious head injury

DO NOT allow this athlete to take aspirin or painkillers as this may mask the signs and symptoms. If the athlete’s headaches are that severe, he/she should seek medical attention.

I would strongly suggest that you check this athlete every 4 hours. Ask the athlete a few simple questions such as: What is your name? Where are you? Then ask a few simple questions regarding what happened at the game or just before/after the game. Next, check for an increase in the severity of three or more of the above signs and symptoms. If you should find that this athlete’s condition is worsening or consistently poor, I would strongly suggest that you take the athlete to the hospital for further examination. Should this situation arise, please call me at any time at the high school at (740) 772-2292.

Thank you,
Policy and Guidelines on Concussions

Grade 1:

No loss of consciousness
Confusion with/without mild or brief amnesia
Other possible symptoms: Headache, dizziness, impaired concentration/orientation, tinnitus, nausea, blurred/double vision, any signs and or symptoms associated with head injuries. Remove athlete from competition pending evaluation

Return to participation:
No Symptoms at rest or exertion
Completely asymptomatic for 20 minutes

Second Concussion (grade 1) during same season
Done for day
Must see to be cleared

Third Concussion (grade 1) during same season
End of athlete’s season

Grade 2:

May or may not have brief loss of consciousness (seconds to five minutes)
Confusion with amnesia, will also show other symptoms
Removed from participation pending evaluation
Out for two weeks, asymptomatic at rest or with exertion
Must be cleared by physician

Grade 3:

Prolonged loss of consciousness (five minutes or more)
Transport to medical facility for evaluation
Return to participation is determined by physician

Prolonged unconsciousness, persistent mental status alterations, worsening post-concussion symptoms, or abnormalities on neurological exam require immediate medical attention.
8/9/2011: Athlete reports being hit multiple times at 8:00, He only complains of some pain at occipital and dizziness. He has full orientation and memory.

8:15 reports feeling a little better. Contacted Dad to come get [Redacted] so he wouldn't drive home. Cell 70302332, Gave Dad head injury sheet

8/10/11- headaches. no practice

8/15/2011: continued minor headache. no practice

[Redacted]
8/18/2009: Pearl, cn 1-12 intact. symptoms: headache, nausea, feels better after ice and rest

[Redacted]
8/8/2011: Reported symptoms at approx 10:45 am. patient states he has headache, is "foggy" and somewhat nauseous; immediate recall 3/5 words;1/5 concentration; 2/5 delayed recall; 3/5 orientation.

Symptoms; headache, dizziness, nausea, light sensitivity, drowsiness, restlessness

at recheck of symptoms at approx 11:05, physical therapist began complaining of midline neck pain and was point tender. EMS was activated as precaution. Pt was stabilized in seated position until EMS arrived.

Sent to Adena regional medical where no fracture was found and sent to Childrens hospital for overnight observation.

8/8/11: Spoke to mother. He is being checked at concussion clinic at Childrens on Monday the 15th.

8/15: Went to Childrens Hospital, out another week until f/u

9/14: Quit team

[Redacted]
8/10/2010: Athlete was tackled and the back of his head hit the ground. Point tender at occipital. Only reports headache
8/9/11
[Redacted],
I am running practices with the girls team Mon-Wed for [Redacted] who is out of town. Yesterday at AM practice [Redacted] took a kicked ball to the side of the face. She didn't say too much and continued to finish the last 15 min of practice. Today when I reported for practice [Redacted] and her mom met me. Her mom said that she had gone on to the fair yesterday and later in the day was experience some dizziness and pain. She was going to take her to urgent care to be seen.
I just heard through a teammate of hers that she was diagnosed with a mild concussion and would be out for a week. I am following that up with a phone call to the [Redacted] and I will keep you posted.
8/10/11
She was the one who got hit in the right side of her face with a kicked ball Monday morning (8/8) at practice. I also talked to her father last night on the phone. She went to urgent care in Waverly the next morning (Tuesday 8/9) after experiencing a headache, blurred vision, and dizziness later in the day Monday. She was told she had a very slight concussion. The doctor wanted an optometrist to see her for the blurred vision, and cleared her with this condition. She saw a optometrist, and he corrected the blurred vision, and cleared her with no restrictions. Her mom brought me the doctor's notes to practice and I attached them to the head injury / medical release form from the handbook. I held her out of all contact drills and anything involving heading of the ball. She took part in the warm-up and stretch, light conditioning drills, and ball work with the feet. I explained to her and her mom that she would be under close observation today and barring any of the symptoms she experienced Monday could return to full practice Thursday. I also advised her to stay away from heading the ball for one week.

[Redacted]
8/10/2011: [Redacted] was hit multiple times during a football drill at practice.. approx 5:00. Patient was visibly disoriented with some difficulty walking. He reports dizziness and drowsiness. He is sensitive to light and confused. blood pressure 120/62. respirations 17. Pulse strong at 86

Testing: Orientation 5/5, concentration 4/5, memory 4/5 all with difficulty. Balance tests..Heel to toe with difficulty. Rhomburg finger to nose was ok. Rhomburg balance inability.

Mother came and took him. She was given a head injury sheet and was taking him to emergency room. Her cell is [Redacted]

Reported to [Redacted] at 5:42. we both will follow up

[Redacted] returned my call at 10:30, she reports that [Redacted] has been moved to Children's Hospital Columbus for observation his CAT scan at Adena came back normal.

8/11/2011: Spoke to [Redacted] at 9:00 this morning. [Redacted] was released at 2:00 am. diagnosis was Grade 2 concussion. Out 2 weeks minimum. Recheck at Concussion clinic.
8/11/2011: Athlete fell and hit her head on soccer field at practice at approx 9:45. It was reported by [Redacted] and I evaluated athlete. Point tender at upper trap with mild headache. No other symptoms.

All concussion texts were 5/5 and balance tests were done without difficulty. Spoke to her mother [Redacted]; I did not permit athlete to drive home.

8/16/2011: Athlete was hit at ear hole. Immediately showed signs of concussion. Taken care of by Uniotos atc, candance. She did concussion eval and activated EMS. Parents met athlete at ER. Treated and released. Will follow up with his PCP on Thursday.

8/18/2011: @ 10:45, Dr. Skocik. Some headache still, Skocik agrees to start concussion progression next week.


Rhomburgs finger to nose, balance and heel to toe all easy.

Spoke to mother [Redacted] and referred to emergency room for scan. Gave her head injury sheet when she picked him up.

After 10 minutes, headache is getting worse, forgetting minor details and drowsy.

8/29: QUIT FOOTBALL

9/2/2011: Athlete was assessed and treated by [Redacted] Certified Athletic Trainer.. She did SCAT testing which he passed except for word recall. Talked to parents about follow up care.. Headache last night which continued into today. Hold out until asymptomatic


Rhombergs and heel to toe both easy. CN 1-12 all good. Pupils equal and reactive to light

Spoke to dad and was taking him to urgent care. 649-6005

9/14/2011: Saw Dr, cat scan negative. Out 2 weeks minimum
9/21/2011: Athlete was in hitting drill when he had the pad slide down and was hit by opposing player. He immediately had pain and dizziness. Difficulty walking to me after the play. He was orientated and memory was 5/5. Balance tests where difficult. Mom 740-998-2222, took him to emergency room.

Out for week

9/22/2011: Athlete reports taking a hit to head at 6:33 pm during freshman game. Came out with headache, dizziness and nausea. Fully oriented and aware. Balance tests were difficult. The game ended shortly after and parents took athlete home. D/C play740-5429203

OUT OF FOOTBALL

9/23/2011: Athlete reported headache, dizziness, nausea and tiredness before the fb game on Friday. He reported hitting his head at the away soccer game on Thursday. did not report to anyone. Spoke to mom to have her take him to emergency room to follow up.

Doctor did not order CT scan. Out til asymptomatic
Concussion Step Process Evaluation Notes
Adena Sports Medicine

Athletes Name: [Redacted]
DOB: 8/15/95
Clearing Physician: Robert

Step 1 Baseline Axon Test: [ ] YES / Date: _______ X] NO Post-Injury Axon Test: [ ] PASS [ ] FAIL

Location of Eval: ABC
Witnesses (es):
Time of Test:

Follow-up/re-eval:
Symptoms Reported: No symptoms on 9/17/12 - was seen in ABC office and cleared to begin stepwise progression.

Pain scale (1-10): _______

Signs observed: ____________________________________________________________

Other information: __________________________________________________________

Assessment: _______________________________________________________________

Plan: _________________________________________________________________

Evaluator: ____________________________ Date: ________________

Step 2

Tuesday 9/18/12

Location of Eval: CHS Fieldhouse
Witnesses (es):
Time of Test: 3:30pm

Follow-up/re-eval:
Symptoms Reported: None

Pain scale (1-10): 0
Pain scale (1-10): ___

Signs observed:

Other information:

Assessment: Progress to Step 3

Plan: Light Aerobic Activity (Walking), Intensity < 70 % MPFR; Monitor @ 15 minute intervals

<table>
<thead>
<tr>
<th>ATC</th>
<th>Athlete Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you have any symptoms of a concussion?</td>
<td>1. No</td>
</tr>
<tr>
<td>2. Do you have a headache?</td>
<td>2. No</td>
</tr>
</tbody>
</table>

Evaluator: Melissa Richendollar            Date: 9/18/12

Step 3 Wednesday 9/19/12

Location of Eval: CHS Fieldhouse
Witnesses (es):
Time of Test: 3:30 pm

Follow-up/re-eval:
Symptoms Reported: No symptoms

Pain scale (1-10): 0

Signs observed:

Other information:

Assessment: Progress to level 4 Thursday

Plan: Jog and Run

<table>
<thead>
<tr>
<th>ATC</th>
<th>Athlete Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you have any symptoms of a concussion?</td>
<td>1. No</td>
</tr>
<tr>
<td>2. Do you have a headache?</td>
<td>2. No</td>
</tr>
</tbody>
</table>

Evaluator: Melissa Richendollar            Date: 9/18/12

Step 4 Thursday or Monday

Location of Eval: CHS Field
Witnesses (es):
Time of Test: 4:15 pm
Signs observed: **NONE**
Other information: **No symptoms reported**
Assessment: **Progress to level 5 on Monday**
Plan: Exertion Testing Evaluation in full gear

<table>
<thead>
<tr>
<th>Testing Sequence</th>
<th>ATC:</th>
<th>Athlete Response:</th>
</tr>
</thead>
</table>
| 1. 10 Push-ups, jog 40 yards, 10 sit-ups, ½ speed 40 yd run | 1. Do you have any symptoms of a concussion?  
2. Do you have a headache? | 1. No  
2. No |
| 2. 10 Push-ups, jog 40 yards, 10 sit-ups, ½ speed 40 yd run | 1. Do you have any symptoms of a concussion?  
2. Do you have a headache? | 1. Yes  
2. Yes |
| 3. 10 jumping jacks, sprint 40 yards, bear crawl 40 yds   | 1. Do you have any symptoms of a concussion?  
2. Do you have a headache? | 1. No  
2. No |
| 4. Sport Specific Drills-No Contact Monitor @15 minute intervals | 1. Do you have any symptoms of a concussion?  
2. Do you have a headache? | 1.  
2. |

Evaluator: **Carroll LeFevre**  
Date: **9-20-12**

Step 5  
**Tuesday 9/25/12**

<table>
<thead>
<tr>
<th>Location of Eval:</th>
<th>CHS Fieldhouse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Witnesses(es):</td>
<td></td>
</tr>
<tr>
<td>Time of Test:</td>
<td>5:00 PM</td>
</tr>
</tbody>
</table>

Follow-up/re-eval:
Symptoms Reported:

Pain scale (1-10): ___

Signs observed: ____________________________

Other information: ____________________________

Assessment: ____________________________

Plan: Full Contact Practice- Monitor @ 30 minute intervals or as necessary

<table>
<thead>
<tr>
<th>ATC</th>
<th>Athlete Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you have any symptoms of a concussion?</td>
<td>1.</td>
</tr>
<tr>
<td>2. Do you have a headache?</td>
<td>2.</td>
</tr>
</tbody>
</table>

Evaluator: ____________________________  
Date: ____________________________
ATC | Athlete Response
---|---
1. Do you have any symptoms of a concussion? | 1. No
2. Do you have a headache? | 2. No

Evaluator: Melissa Rickerdler | Date: 9/17/12

Step 6 | 9/28/12

| Location of Eval: | Gullia Academy |
| Witnesses (es): | |
| Time of Test: | |

Follow-up/re-eval:
Symptoms Reported:

Pain scale (1-10): __

Signs observed:

Other information: ______________________________________

Assessment: ______________________________________

Plan: Normal game play: Monitor as Necessary

Evaluator: _____________________________ Date: ____________
Concussion Step Process Evaluation Notes

Adena Sports Medicine

Athletes Name: [Redacted]

DOB: __________

Clearing Physician: Dr. Roberts

Step 1 Baseline Axon Test: [ ] YES / Date: _____ X [ ] NO Post-Injury Axon Test: [ ] PASS [ ] FAIL

<table>
<thead>
<tr>
<th>Location of Eval:</th>
<th>CHS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Witnesses (es):</td>
<td>AA</td>
</tr>
<tr>
<td>Time of Test:</td>
<td>9/21/12 9/28/12</td>
</tr>
</tbody>
</table>

Follow-up/re-eval:
Symptoms Reported: 0

Pain scale (1-10): __

Signs observed:

Other information: Clearance on 9/28/12

Assessment:

Plan:

Evaluator: Andrea Anderson Date: 9/30/12

Step 2

<table>
<thead>
<tr>
<th>Location of Eval:</th>
<th>CHS Fieldhouse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Witnesses (es):</td>
<td>AA</td>
</tr>
<tr>
<td>Time of Test:</td>
<td>3:00 4:00 9/29 a 9/30</td>
</tr>
</tbody>
</table>

Follow-up/re-eval:
Symptoms Reported: 0

Pain scale (1-10): ___
Pain scale (1-10): _____

Signs observed:  

Other Information:  

Assessment:  

Plan: Light Aerobic Activity (Walking), Intensity < 70 % MPHR; Monitor @ 15 minute intervals

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<td>2. Do you have a headache?</td>
<td>2. No</td>
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</tbody>
</table>

Evaluator: Andrea Anderson  Date: 9/30/12

Step 3

<table>
<thead>
<tr>
<th>Location of Eval:</th>
<th>CHS Fieldhouse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Witnesses (es):</td>
<td></td>
</tr>
<tr>
<td>Time of Test:</td>
<td>3:00 10/1/12</td>
</tr>
</tbody>
</table>

Follow-up/re-eval:

Symptoms Reported:  

Pain scale (1-10): _____

Signs observed:  

Other Information:  

Assessment:  

Plan: Jog and Run

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>1. Do you have any symptoms of a concussion?</td>
<td>1. No</td>
</tr>
<tr>
<td>2. Do you have a headache?</td>
<td>2. No</td>
</tr>
</tbody>
</table>

Evaluator: Andrea Anderson ATC  Date: 10/1/12

Step 4

<table>
<thead>
<tr>
<th>Location of Eval:</th>
<th>CHS Fieldhouse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Witnesses (es):</td>
<td></td>
</tr>
<tr>
<td>Time of Test:</td>
<td>10/2/12</td>
</tr>
</tbody>
</table>
Signs observed: 8

Other information:

Assessment:

Plan: Exertion Testing Evaluation in full gear

<table>
<thead>
<tr>
<th>Testing Sequence</th>
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<tr>
<td>1. 10 Push-ups, jog 40 yards, 10 sit-ups, ½ speed 40 yd run</td>
<td>1. Do you have any symptoms of a concussion? 2. Do you have a headache?</td>
<td>1. No 2. No</td>
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<tr>
<td>2. 10 Push-ups, jog 40 yards, 10 sit-ups, ½ speed 40 yd run</td>
<td>1. Do you have any symptoms of a concussion? 2. Do you have a headache?</td>
<td>1. No 2. No</td>
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<td>3. 10 jumping jacks, sprint 40 yards, bear crawl 40 yds</td>
<td>1. Do you have any symptoms of a concussion? 2. Do you have a headache?</td>
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<tr>
<td>4. Sport Specific Drills-No Contact Monitor @15 minute intervals</td>
<td>1. Do you have any symptoms of a concussion? 2. Do you have a headache?</td>
<td>1. No 2. No</td>
</tr>
</tbody>
</table>

Evaluator: Andrea Anderson ATC Date: 10/21/12

Step 5

<table>
<thead>
<tr>
<th>Location of Eval:</th>
<th>Witnesses (es):</th>
<th>Time of Test:</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Fieldhouse</td>
<td></td>
<td>10/31/12</td>
</tr>
</tbody>
</table>

Follow-up/re-eval:
Symptoms Reported: 

Pain scale (1-10):

Signs observed: 

Other information:

Assessment:

Plan: Full Contact Practice- Monitor @ 30 minute intervals or as necessary

<table>
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<td>1. Do you have any symptoms of a concussion? 2. Do you have a headache?</td>
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</table>

Evaluator: Andrea Anderson ATC Date: 10/31/12
ATC
1. Do you have any symptoms of a concussion?
2. Do you have a headache?

Athlete Response

Evaluator: ___________________________ Date: ___________________________

Step 6

Location of Eval: ___________________________
Witnesses (es): ___________________________
Time of Test: 11/4/12

Follow-up/re-eval:
Symptoms Reported: ☐

Pain scale (1-10): __________

Signs observed: ☐

Other information: ___________________________

Assessment: ___________________________

Plan: Normal game play: Monitor as Necessary

Evaluator: Andrea Anderson ATC Date: 11/4/12
SPORTS MEDICINE

Date: 9/28/12
Name: [Redacted] School: Chillicothe
Phone: __________ Grade: 10 Age: 15

Date of Injury: __________ ABJC Patient: __________ New
Sport: Football __________ Follow-Up (New)
Coach: __________ Follow-Up (Previous)

Diagnosis: __________________________________________________________________________

Plan of Care:

☐ X-Ray ____________________ ☐ Physical Therapy ____________________
☐ Brace ____________________ ☐ MRI ____________________
☐ Medications ____________________ ☐ Other Testing ____________________
☐ HEP ____________________ ☐ Surgery ____________________

OK for [Redacted] Return to Play

____________________________________________________________________________________

Recommendations:

☐ No restrictions – return to full activity ______________________________
☐ Restricted activity ______________________________
☐ No practice or play until ______________________________
☐ Hold from gym class ______________________________

Return for further care ______________________________

Physician __________________________ Athletic Trainer __________________________

CLI.7042-0810 (740) 779-4598 Fax (740) 779-4599 Toll Free (877) 779-4598
Concussion Step Process Evaluation Notes

Athletes Name: [Redacted]
DOB: 3/9/98
Clearing Physician: Dr. Strauch

Step 1 Baseline Axon Test: [ NOT ] YES / Date: 07/09/2018
Post-Injury Axon Test: [ NOT ] PASS [ NOT ] FAIL

| Location of Eval: | CHS Fieldhouse |
| Witnesses (es): | Melissa Richendollar |
| Time of Test: | 4:30 pm |

Follow-up/re-eval:
Symptoms Reported: 0 symptoms over the weekend 9/22-9/23

Pain scale (1-10): [Redacted]

Signs observed: [Redacted]

Other information: [Redacted]

Assessment: [Redacted]

Plan: Continue to step 2 on 9/24 over the weekend 9/22-9/23

Evaluator: Andrea Anderson ATC Date: 9/21/12

Step 2

| Location of Eval: | CHS Fieldhouse |
| Witnesses (es): | Melissa Richendollar |
| Time of Test: | [Redacted] |

Follow-up/re-eval:
Symptoms Reported: 0 symptoms over the weekend 9/22-9/23

Pain scale (1-10): [Redacted]
Pain scale (1-10): ___

Signs observed: ____________

Other information: __________________________

Assessment: Progress to step 3 on 9/24

Plan: Light Aerobic Activity (Walking), Intensity < 70 % MPHR; Monitor @ 15 minute intervals

<table>
<thead>
<tr>
<th>ATC</th>
<th>Athlete Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you have any symptoms of a concussion?</td>
<td>1. No</td>
</tr>
<tr>
<td>2. Do you have a headache?</td>
<td>2. No</td>
</tr>
</tbody>
</table>

Evaluator: Andrea Anderson ATC Date: 9/24/12

Step 3

<table>
<thead>
<tr>
<th>Location of Eval:</th>
<th>CHS Fieldhouse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Witnesses (es):</td>
<td>Melissa Richendollar</td>
</tr>
<tr>
<td>Time of Test:</td>
<td></td>
</tr>
</tbody>
</table>

Follow-up/re-eval:
Symptoms Reported: O symptoms

Pain scale (1-10): ___

Signs observed: ____________

Other information: __________________________

Assessment: Progress to step 4 on 9/25

Plan: Jog and Run

<table>
<thead>
<tr>
<th>ATC</th>
<th>Athlete Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you have any symptoms of a concussion?</td>
<td>1. No</td>
</tr>
<tr>
<td>2. Do you have a headache?</td>
<td>2. No</td>
</tr>
</tbody>
</table>

Evaluator: Andrea Anderson ATC Date: 9/24/12

Step 4

<table>
<thead>
<tr>
<th>Location of Eval:</th>
<th>CHS Fieldhouse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Witnesses (es):</td>
<td></td>
</tr>
<tr>
<td>Time of Test:</td>
<td>3:00 PM</td>
</tr>
</tbody>
</table>
**Signs observed:**

**Other information:**

**Assessment:** Progress to step 5 on 9/26

**Plan:** Exertion Testing Evaluation in full gear

<table>
<thead>
<tr>
<th>Testing Sequence</th>
<th>ATC:</th>
<th>Athlete Response:</th>
</tr>
</thead>
</table>
| 1. 10 Push-ups, jog 40 yards, 10 sit-ups, ½ speed 40 yd run                     | 1. Do you have any symptoms of a concussion?  
2. Do you have a headache?                                                      | 1. No  
2. No  |
| 2. 10 Push-ups, jog 40 yards, 10 sit-ups, ½ speed 40 yd run                     | 1. Do you have any symptoms of a concussion?  
2. Do you have a headache?                                                      | 1. No  
2. No  |
| 3. 10 jumping jacks, sprint 40 yards, bear crawl 40 yds                         | 1. Do you have any symptoms of a concussion?  
2. Do you have a headache?                                                      | 1. Some Dizziness  
2. No  |
| 4. Sport Specific Drills-No Contact Monitor @15 minute intervals                | 1. Do you have any symptoms of a concussion?  
2. Do you have a headache?                                                      | 1. No  
2. No  |

**Evaluator:** Andrea Anderson ATC  
**Date:** 9/26/12

**Step 5  9/26/12**

**Location of Eval:** CHS Fieldhouse  
**Witnesses (es):**

**Time of Test:** 2:30PM

**Follow-up/re-eval:**

Symptoms Reported: 

**Pain scale (1-10):** 0  

**Signs observed:**

**Other information:**

**Assessment:** Progress to step 6

**Plan:** Full Contact Practice- Monitor @ 30 minute intervals or as necessary

<table>
<thead>
<tr>
<th>ATC</th>
<th>Athlete Response</th>
</tr>
</thead>
</table>
| 1. Do you have any symptoms of a concussion?  
2. Do you have a headache?             | 1. No  
2. No  |

**Evaluator:** Andrea Anderson  
**Date:** 9/26/12
<table>
<thead>
<tr>
<th>ATC</th>
<th>Athlete Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Do you have any symptoms of a concussion?</td>
</tr>
<tr>
<td>2.</td>
<td>Do you have a headache?</td>
</tr>
</tbody>
</table>

Evaluator: ___________________________ Date: ____________

Step 6

<table>
<thead>
<tr>
<th>Location of Eval:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Witnesses (es):</td>
</tr>
<tr>
<td>Time of Test:</td>
</tr>
</tbody>
</table>

Follow-up/re-eval:
Symptoms
Reported: ___________________________________________________________

Pain scale (1-10):__

Signs observed: ______________________________________________________

Other information: ____________________________________________________

Assessment: __________________________________________________________

Plan: Normal game play: Monitor as Necessary

Evaluator: ___________________________ Date: ____________
Post Concussion

Date: 9/21/12

Athlete: [Redacted]

Sport: FB

Dear: Andrea

Physician Diagnosis: Concussion

Return to Activity:
- No Activity
- May resume stepwise return to activity as below
- The athlete must see me again prior to resuming activities
- Special Instructions

<table>
<thead>
<tr>
<th>Weekday</th>
<th>Activity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Step 1</td>
<td>Rest until asymptomatic (physical and mental)</td>
</tr>
<tr>
<td>Monday</td>
<td>No activity (resumed a/c/ activity)</td>
</tr>
<tr>
<td>Tuesday</td>
<td>Light aerobic exercise (NO IMPACT) such as walking, stationary bike, or swimming.</td>
</tr>
<tr>
<td>Wednesday</td>
<td>Running and sport-specific training (ball handling, sit-ups, push-ups).</td>
</tr>
<tr>
<td>Thursday</td>
<td>May practice; Non-contact drills; no hitting or live contact.</td>
</tr>
<tr>
<td>Friday</td>
<td>Full contact training after medical clearance.</td>
</tr>
<tr>
<td>Saturday</td>
<td>Game play</td>
</tr>
</tbody>
</table>

There should be approximately 24 hours (or longer) for each stage, and the athlete should stop activity and return to stage 1 if symptoms recur.

Follow-Up:
- Time
- Not necessary

Other:

Physician Signature

6/10/2007
Concussion Step Process Evaluation Notes
Adena Sports Medicine

Athletes Name: [Redacted]
DOB: [Redacted]
Clearing Physician: Thompson

Step 1  Baseline Axon Test: [ ] YES / Date: [Redacted]  X NO  Post-Injury Axon Test: [ ] PASS  [ ] FAIL

| Location of Eval: | ABC
| Witnesses (es): | [Redacted] |
| Time of Test: | [Redacted] |

Follow-up/re-eval:
Symptoms Reported:

Pain scale (1-10): [Redacted]
Signs observed:

Other information:
Assessment:
Plan:
Evaluator: [Redacted] Date:

Step 2  Tues 9/18/12

| Location of Eval: | CHS fieldhouse
| Witnesses (es): | [Redacted] |
| Time of Test: | [Redacted] |

Follow-up/re-eval:
Symptoms Reported:

Pain scale (1-10): [Redacted]
Pain scale (1-10): __

Signs observed:

Other information:

Assessment: Progress to level 3

Plan: Light Aerobic Activity (Walking), Intensity < 70% MPHR; Monitor @ 15 minute intervals

<table>
<thead>
<tr>
<th>ATC</th>
<th>Athlete Response</th>
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<tr>
<td>1. Do you have any symptoms of a concussion?</td>
<td>1. No</td>
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<tr>
<td>2. Do you have a headache?</td>
<td>2. No</td>
</tr>
</tbody>
</table>

Evaluator: Melissa Richendolla Date: 9/18/12

Step 3

<table>
<thead>
<tr>
<th>Location of Eval:</th>
<th>CHS field house</th>
</tr>
</thead>
<tbody>
<tr>
<td>Witnesses (es):</td>
<td></td>
</tr>
<tr>
<td>Time of Test:</td>
<td>3:30pm</td>
</tr>
</tbody>
</table>

Follow-up/re-eval:

Symptoms Reported: None

Pain scale (1-10): 0

Signs observed:

Other information:

Assessment: Progress to level 4

Plan: Jog and Run

<table>
<thead>
<tr>
<th>ATC</th>
<th>Athlete Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you have any symptoms of a concussion?</td>
<td>1. No</td>
</tr>
<tr>
<td>2. Do you have a headache?</td>
<td>2. No</td>
</tr>
</tbody>
</table>

Evaluator: Melissa Richendolla Date: 9/19/12

Step 4

<table>
<thead>
<tr>
<th>Location of Eval:</th>
<th>CHS Field</th>
</tr>
</thead>
<tbody>
<tr>
<td>Witnesses (es):</td>
<td></td>
</tr>
<tr>
<td>Time of Test:</td>
<td>4:15 pm</td>
</tr>
</tbody>
</table>
Signs observed: NONE
Other Information: No symptoms reported
Assessment: Progress to level 5 on Monday
Plan: Exertion Testing Evaluation in full gear

<table>
<thead>
<tr>
<th>Testing Sequence</th>
<th>ATC:</th>
<th>Athlete Response:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 10 Push-ups, jog 40 yards, 10 sit-ups, ½ speed 40 yd run</td>
<td>1. Do you have any symptoms of a concussion? 2. Do you have a headache?</td>
<td>1. No 2. No</td>
</tr>
<tr>
<td>2. 10 Push-ups, jog 40 yards, 10 sit-ups, ½ speed 40 yd run</td>
<td>1. Do you have any symptoms of a concussion? 2. Do you have a headache?</td>
<td>1. No 2. No</td>
</tr>
<tr>
<td>3. 10 jumping jacks, sprint 40 yards, bear crawl 40 yds</td>
<td>1. Do you have any symptoms of a concussion? 2. Do you have a headache?</td>
<td>1. No 2. No</td>
</tr>
<tr>
<td>4. Sport Specific Drills-No Contact Monitor @15 minute intervals</td>
<td>1. Do you have any symptoms of a concussion? 2. Do you have a headache?</td>
<td>1. No 2. No</td>
</tr>
</tbody>
</table>

Evaluator: Candace Haynes  Date: 9-20-12

Step 5  Tuesday 9/25/12

<table>
<thead>
<tr>
<th>Location of Eval:</th>
<th>CHS Fieldhouse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Witnesses (es):</td>
<td></td>
</tr>
<tr>
<td>Time of Test:</td>
<td>3:00 PM</td>
</tr>
</tbody>
</table>

Follow-up/re-eval:
Symptoms Reported: 0 symptoms
Pain scale (1-10): 0
Signs observed:

Other information:

Assessment: Progress to step 6 on 9/26
Plan: Full Contact Practice- Monitor @ 30 minute intervals or as necessary

<table>
<thead>
<tr>
<th>ATC</th>
<th>Athlete Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you have any symptoms of a concussion? 2. Do you have a headache?</td>
<td>1. No 2. No</td>
</tr>
</tbody>
</table>

Evaluator: Andrea Anderson ATC  Date: 9/26/12
Step 6  9/28/12

Location of Eval: Atholcofte Fieldhouse Sparta Academy
Witnesses (es):

Time of Test: 3:30PM

Follow-up/re-eval:
Symptoms Reported:

Pain scale (1-10):

Signs observed:

Other information:

Assessment:

Plan: Normal game play: Monitor as Necessary

Evaluator: ____________________________ Date: ________________
SPORTS MEDICINE

Date: 9-17-12
Name: [Redacted] School: Chillicothe High School
Phone: [Redacted] Grade: 11+ Age: 17+
Date of Injury: 9-14-12 ABJC Patient: X New
Sport: Football Follow-Up (New)
Coach: [Redacted] Follow-Up (Previous)
Diagnosis: Concussion

Plan of Care:
- X-Ray
- Brace
- Medications
- HEP
- Physical Therapy
- MRI
- Other Testing
- Surgery

To start return to play progression
Sports specific drills
Full return After Friday

Recommendations:
- No restrictions – return to full activity
- Restricted activity
- No practice or play until
- Hold from gym class

Return for further care

Physician

Athletic Trainer

CLI.7042-0810 (740) 779-4598 Fax (740) 779-4599 Toll Free (877) 779-4598
Concussion Step Process Evaluation Notes

Adena Sports Medicine

Athletes Name: [Redacted]

DOB: [Redacted]

Clearing Physician: Dr. Alan Noel

Step 1 Baseline Axon Test: [ ] YES / Date: [Redacted] [x] NO Post-Injury Axon Test: [ ] PASS [ ] FAIL

Location of Eval: 

Witnesses (es): 

Time of Test: 9/27/10

Follow-up/re-eval:

Symptoms Reported: 

Pain scale (1-10): 

Signs observed: 

Other information: 

Assessment: 

Plan: 

Evaluator: Andrea Anderson ATC Date: 9/27/10

Step 2 9/27/12 / 9/29/12 / 10/1/12

Location of Eval: Mount Logan

Witnesses (es): 

Time of Test: 6:00 PM

Follow-up/re-eval:

Symptoms Reported: Headache but not from running, fell fine, jogging

Pain scale (1-10): 

"for Head hurt w/ running"
Pain scale (1-10):____
Signs observed: Ø
Other information: 
Assessment: Check 9/28 to determine RTP progression
Plan: Light Aerobic Activity (Walking), Intensity < 70 % MPH; Monitor @ 15 minute intervals

<table>
<thead>
<tr>
<th>ATC</th>
<th>Athlete Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you have any symptoms of a concussion?</td>
<td>1. No</td>
</tr>
<tr>
<td>2. Do you have a headache?</td>
<td>2. Yes</td>
</tr>
</tbody>
</table>

Evaluator: Andrea Anderson Date: 9/27/12

Step 3
9/28/12 / 9/29/12 / 10/1/12

<table>
<thead>
<tr>
<th>Location of Eval:</th>
<th>Practice Field</th>
</tr>
</thead>
<tbody>
<tr>
<td>Witnesses (es):</td>
<td></td>
</tr>
<tr>
<td>Time of Test:</td>
<td>2:30 PM</td>
</tr>
</tbody>
</table>

Follow-up/re-eval:
Symptoms Reported: Headache
Pain scale (1-10):____
Signs observed: 
Other information: Headache worse today 9/28 - 9/29 headache w/ jogging
Assessment: Rest until headache goes away 10/1 - no symptoms w/ jogging
Plan: Jog and Run

<table>
<thead>
<tr>
<th>ATC</th>
<th>Athlete Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you have any symptoms of a concussion?</td>
<td>1. No</td>
</tr>
<tr>
<td>2. Do you have a headache?</td>
<td>2. No</td>
</tr>
</tbody>
</table>

Evaluator: Andrea Anderson ATC Date: 10/1/12

Step 4
Location of Eval: Mount Logan
Witnesses (es): 
Time of Test: 10/2/12
### Testing Sequence

<table>
<thead>
<tr>
<th>Testing Sequence</th>
<th>ATC:</th>
<th>Athlete Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. 10 Push-ups, jog 40 yards, 10 sit-ups, ½ speed 40 yd run</td>
<td>1. Do you have any symptoms of a concussion?</td>
<td>1. No</td>
</tr>
<tr>
<td></td>
<td>2. Do you have a headache?</td>
<td>2. No</td>
</tr>
<tr>
<td>2. 10 Push-ups, jog 40 yards, 10 sit-ups, ½ speed 40 yd run</td>
<td>1. Do you have any symptoms of a concussion?</td>
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</tr>
<tr>
<td></td>
<td>2. Do you have a headache?</td>
<td>2. No</td>
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<tr>
<td>3. 10 jumping jacks, sprint 40 yards, bear crawl 40 yds</td>
<td>1. Do you have any symptoms of a concussion?</td>
<td>1. No</td>
</tr>
<tr>
<td></td>
<td>2. Do you have a headache?</td>
<td>2. No</td>
</tr>
<tr>
<td>4. Sport Specific Drills-No Contact Monitor @15 minute intervals</td>
<td>1. Do you have any symptoms of a concussion?</td>
<td>1. No</td>
</tr>
<tr>
<td></td>
<td>2. Do you have a headache?</td>
<td>2. No</td>
</tr>
</tbody>
</table>

Evaluator: Andrea Anderson ATC  
Date: 10/2/12

### Follow-up/re-eval:

Symptoms Reported:  

Pain scale (1-10):  

Signs observed:  

### Plan:

Full Contact Practice- Monitor @ 30 minute intervals or as necessary
ATC

1. Do you have any symptoms of a concussion?
2. Do you have a headache?

Athlete Response

1.
2.

Evaluator: ____________________________ Date: ____________________________

Step 6

<table>
<thead>
<tr>
<th>Location of Eval:</th>
<th>Zane Trace HS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Witnesses (es):</td>
<td></td>
</tr>
<tr>
<td>Time of Test:</td>
<td>10/5/12</td>
</tr>
</tbody>
</table>

Follow-up/re-eval:

Symptoms Reported: [ ]

Pain scale (1-10): __

Signs observed: [ ]

Other information: ________________________________________________________

Assessment: _____________________________________________________________

Plan: Normal game play: Monitor as Necessary

Evaluator: Andrea Anderson ATC Date: 10/5/12
Date: 09/27/2012

473 W Main St
Chillicothe OH 45601

To whom it may concern,

The above patient has been clear to play sports as of 9/27/2012. Please feel free to contact my office with any question regarding this at 740-779-4500 during regular business hours Monday thru Friday 8-5.

Sincerely,

[Signature]

Adena Pickaway Ross Family Medicine

Dr. Alan Noel
100 N. Walnut Street
Chillicothe, OH 45601
Phone (740) 779-4500
Fax (740) 779-4524
Standard Assessment of Concussion-SAC

Name: [redacted]
Team: CHS
Examiner: [redacted]
Date of Exam: 9/18/12
Time: 4:30pm

Exam (Circle One): BLine Injury Post-Px/Game
Day 1 Day 2 Day 3 Day 5 Day 7 Day 90

Introduction:
I am going to ask you some questions. Please listen carefully and give your best effort.

Orientation:
What Month is it? 0
What's the Date Today? 0
What's the Day of the Week? 0
What Year is it? 0
What Time is it right now (within 1 hr)? 0

Award 1 point for each correct answer.

ORIENTATION TOTAL SCORE: 5

Immediate Memory:
I am going to test your memory. I will read you a list of words and when I am done repeat back as many words as you can remember, in any order.

List
Elbow
Apple
Carpet
Saddle
Bubble

Trial 1 Trial 2 Trial 3
0 0 0
1 0 1
1 0 1
1 0 1
1 0 1

Total 5 5 5

Trials 2 & 3: I am going to repeat that list again. Repeat back as many words as you can remember in any order, even if I said the word before.

Complete all 3 trials regardless of score on trial 1 & 2. Score 1 pt for each correct response. Total score equals sum across all 3 trials.

Do not inform the subject that delayed recall will be tested.

IMMEDIATE MEMORY TOTAL SCORE: 15

Exertional Maneuvers:
If subject is not displaying or reporting symptoms, conduct the following maneuvers to create conditions under which symptoms are likely to be elicited and detected. These measures need not be conducted if a subject is already displaying or reporting any symptoms. If not conducted allow 2 minutes to keep time delay constant before testing Delayed Recall. These methods should be administered for baseline testing of normal subjects.

Exertional Maneuvers
5 Jumping Jacks
5 Push-ups
5 Sit ups
5 Knee bends

Neurologic Screening:
Loss of Consciousness/Witnessed Unresponsiveness
No
Yes

Post Traumatic Amnesia?
Poor recall of events after the injury
No
Yes

Retrograde Amnesia?
Poor recall of events before the injury
No
Yes

Strength
Right Upper Extremity Normal
Left Upper Extremity
Right Lower Extremity
Left Lower Extremity

Sensation – examples:
Finger to nose/Romberg OK

Coordination – examples:
Tandem walk/Finger-nose-finger unsteady

Concentration:
Digits Backwards: I am going to read you a string of numbers and when I am done, you repeat them back to me backwards, in reverse order of how I read them to you. For example, if I say 7-1-5, you would say 9-1-7.

If correct, go to next string length, if incorrect, read trial 2. Score 1 pt for each string length. Stop after incorrect on both sides.

4-9-3 6-2-9 3-5-1-4 9 3-2-7-9 6-2-6-7-1 1-5-2-8-6 7-1-8-6-5 5-3-9-1-4-8

Months in Reverse Order: Now tell me the months of the year in reverse order. Start with the last month and go backwards. So you'll say December, November...Go ahead.
1 pt. for entire sequence correct.

CONCENTRATION TOTAL SCORE: 1

Delayed Recall:
Do you remember that list of words I read a few times earlier? Tell me as many words from the list as you can remember in any order. Circle each word correctly recalled. Total score equals number of words recalled.

Elbow Apple Carpet Saddle Bubble

DELAYED RECALL TOTAL SCORE: 4

SAC Scoring Summary:
Exertional Maneuvers & Neurologic Screening are important for examination, but not incorporated into SAC Total Score.

Orientation 5/5
Immediate Memory 15/15
Concentration 1/5
Delayed Recall 4/5

SAC Total Score 26/30
Concussion Step Process Evaluation Notes

Adena Sports Medicine

Athletes Name: [Redacted]
DOB: 12/9/07
Clearing Physician: Dr. Shaw

Step 1 Baseline Axon Test: [ ] YES / Date: [Redacted] 
NO Post-Injury Axon Test: [ ] PASS [ ] FAIL

| Location of Eval: | Cats field house |
| Witnesses (es): | Andrea Anderson |
| Time of Test: | 3:00 pm |

Follow-up/re-eval:
Symptoms Reported: No symptoms on Friday 9/21/12

Pain scale (1-10): [Redacted]

Signs observed: [Redacted]

Other information: [Redacted]

Assessment: [Redacted]

Plan: Continue to step 2 on 9/24/12

Evaluator: Melissa Richendollar Date: 9/21/12

Step 2

| Location of Eval: | Cats field house |
| Witnesses (es): | [Redacted] |
| Time of Test: | [Redacted] |

Follow-up/re-eval:
Symptoms Reported: has headache at end of school day

Pain scale (1-10): [Redacted]
Pain scale (1-10): 

Signs observed:

Other information:

Assessment: Per note from Dr. Shaw, he needs recheck if H/A after 48 hr.

Plan: Light Aerobic Activity (Walking), Intensity < 70 % MPHR; Monitor @ 15 minute intervals

<table>
<thead>
<tr>
<th>ATC</th>
<th>Athlete Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you have any symptoms of a concussion?</td>
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<tr>
<td>2. Do you have a headache?</td>
<td>2. Yes</td>
</tr>
</tbody>
</table>

Evaluator: Melissa Richendollar Date: 9/24/12

Step 3 9/25

<table>
<thead>
<tr>
<th>Location of Eval:</th>
<th>CHS Fieldhouse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Witnesses (es):</td>
<td></td>
</tr>
<tr>
<td>Time of Test:</td>
<td>3:00 PM</td>
</tr>
</tbody>
</table>

Follow-up/re-eval:
Symptoms Reported: 0 symptoms

Pain scale (1-10): 0

Signs observed:

Other information:

Assessment: Progress to step 4 on 9/26

Plan: Jog and Run

<table>
<thead>
<tr>
<th>ATC</th>
<th>Athlete Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Do you have any symptoms of a concussion?</td>
<td>1. No</td>
</tr>
<tr>
<td>2. Do you have a headache?</td>
<td>2. No</td>
</tr>
</tbody>
</table>

Evaluator: Andrea Anderson, ATC Date: 9/25/12

Step 4

<table>
<thead>
<tr>
<th>Location of Eval:</th>
<th>CHS Fieldhouse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Witnesses (es):</td>
<td></td>
</tr>
<tr>
<td>Time of Test:</td>
<td>3:00 PM</td>
</tr>
</tbody>
</table>
Assessment: Progress to step 5 on 9/27

Plan: Exertion Testing Evaluation in full gear

<table>
<thead>
<tr>
<th>Testing Sequence</th>
<th>ATC:</th>
<th>Athlete Response:</th>
</tr>
</thead>
</table>
| 1. 10 Push-ups, jog 40 yards, 10 sit-ups, ½ speed 40 yd run | 1. Do you have any symptoms of a concussion?  
2. Do you have a headache? | 1. No  
2. No |
| 2. 10 Push-ups, jog 40 yards, 10 sit-ups, ½ speed 40 yd run | 1. Do you have any symptoms of a concussion?  
2. Do you have a headache? | 1. No  
2. No |
| 3. 10 jumping jacks, sprint 40 yards, bear crawl 40 yds | 1. Do you have any symptoms of a concussion?  
2. Do you have a headache? | 1. No  
2. No |
| 4. Sport Specific Drills-No Contact Monitor @15 minute intervals | 1. Do you have any symptoms of a concussion?  
2. Do you have a headache? | 1. No  
2. No |

Evaluator: Andrea Anderson ATC  
Date: 9/26/12

Step 5

Location of Eval: CHK Fieldhouse  
Witnesses (es):  
Time of Test:

Follow-up/re-eval:
Symptoms Reported:  
Pain scale (1-10):  
Signs observed:  
Other information:  
Assessment:  
Plan: Full Contact Practice- Monitor @ 30 minute intervals or as necessary

<table>
<thead>
<tr>
<th>ATC</th>
<th>Athlete Response</th>
</tr>
</thead>
</table>
| 1. Do you have any symptoms of a concussion?  
2. Do you have a headache? | 1.  
2. |

Evaluator:  
Date:  

3
### ATC
1. Do you have any symptoms of a concussion?
2. Do you have a headache?

<table>
<thead>
<tr>
<th>Athlete Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
</tr>
<tr>
<td>2.</td>
</tr>
</tbody>
</table>

Evaluator: ___________________________ Date: __________________

---

**Step 6**

<table>
<thead>
<tr>
<th>Location of Eval:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Witnesses (es):</td>
</tr>
<tr>
<td>Time of Test:</td>
</tr>
</tbody>
</table>

---

**Follow-up/re-eval:**

Symptoms Reported: ____________________________________________

Pain scale (1-10): ______

Signs observed: ____________________________________________

Other information: ________________________________________

Assessment: _____________________________________________

Plan: Normal game play: Monitor as Necessary

Evaluator: ___________________________ Date: ________________
Adena Sports Medicine Concussion Return to Play Form

Athlete's Name: [Redacted]  
School: CHS  
Team / Sport: Football  
Date of Birth: 1/29/97

Date of Injury: 9/18/12  
☐ please see attached information

<table>
<thead>
<tr>
<th>Did the athlete have:</th>
<th>(Circle One)</th>
<th>Duration/Resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of consciousness or unresponsiveness?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Seizure or convulsive activity?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Balance problems/unsteadiness?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Dizziness?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Headache?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Nausea or vomiting?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Emotional instability?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Confusion?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Difficulty concentrating?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Vision Problems?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Memory loss after or prior to injury?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Other:</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

Athletic Trainer: Melissa Bichendollard  
Date: 9/18/12

PHYSICIAN RECOMMENDATIONS: The following are the return to sports recommendations at the present time

☐ Do NOT return to sports practice or competition at this time  
   - off 1 week: if no
     - headache after 24-48, can return to practice in 1 week.

☐ May return to sports practice via stepwise protocol under the supervision of the team health care provider
   - off 9/14/12 thru 9/26/12
   - may return to full practice.

☐ Must return to Physician for final clearance to return to competition
   - off 9/14/12 thru 9/26/12

☐ FULL CLEARANCE: May return to full participation in ALL activities (PE and Sports)

☐ Axon computer based concussion testing done [ ] PASS [ ] FAIL  
   Date: __________

Return to this office on (date/time) __________________________  
☐ No follow-up needed

Additional Comments: ________________________________

Medical Office Information (Please Print/Stamp)

Physician’s Name: [Redacted]  
Physician’s Office Address: 272 Hospital Dr., Chillicothe, OH  
Physician’s Phone (Redacted): 729-4100  
Physician’s Signature: ____________________________  
M.D. | D.O. Date: 9/19/12
Adena Sports Medicine Concussion Return to Play Form

Athlete's Name ____________________________ Date of Birth: ____________________________

School: Chillicothe HS Team / Sport: Varsity Football

Date of Injury: 10/12/12 □ please see attached information

Did the athlete have:

<table>
<thead>
<tr>
<th></th>
<th>(Circle One)</th>
<th>Duration/Resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of consciousness</td>
<td>Yes [X]</td>
<td></td>
</tr>
<tr>
<td>or unresponsiveness?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Seizure or convulsive</td>
<td>Yes [X]</td>
<td></td>
</tr>
<tr>
<td>activity?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Balance problems/unsteadiness?</td>
<td>Yes [X]</td>
<td>If yes, has this resolved? Yes</td>
</tr>
<tr>
<td>Dizziness?</td>
<td>Yes [X]</td>
<td>If yes, has this resolved? Yes</td>
</tr>
<tr>
<td>Headache?</td>
<td>Yes [X]</td>
<td>If yes, has this resolved? Yes</td>
</tr>
<tr>
<td>Nausea or vomiting?</td>
<td>Yes [X]</td>
<td>If yes, has this resolved? Yes</td>
</tr>
<tr>
<td>Emotional instability?</td>
<td>Yes [X]</td>
<td>If yes, has this resolved? Yes</td>
</tr>
<tr>
<td>Confusion?</td>
<td>Yes [X]</td>
<td>If yes, has this resolved? Yes</td>
</tr>
<tr>
<td>Difficulty concentrating?</td>
<td>Yes [X]</td>
<td>If yes, has this resolved? Yes</td>
</tr>
<tr>
<td>Vision Problems?</td>
<td>Yes [X]</td>
<td>If yes, has this resolved? Yes</td>
</tr>
<tr>
<td>Memory loss after or prior to injury?</td>
<td>Yes [X]</td>
<td>If yes, has this resolved? Yes</td>
</tr>
<tr>
<td>Other:</td>
<td>Yes [X]</td>
<td>If yes, has this resolved? Yes</td>
</tr>
</tbody>
</table>

Athletic Trainer: Andrea Anderson ATC Date: 10/13/12

PHYSICIAN RECOMMENDATIONS: The following are the return to sports recommendations at the present time

□ Do NOT return to sports practice or competition at this time

□ May return to sports practice via stepwise protocol under the supervision of the team health care provider

□ Must return to Physician for final clearance to return to competition

□ FULL CLEARANCE: May return to full participation in ALL activities (PE and Sports)

□ Axon computer based concussion testing done [ ] PASS [ ] FAIL Date: __________

Return to this office on (date/time) ________________________________________________ □ No follow-up needed

Additional Comments: ______________________________________________________________

Medical Office Information (Please Print/Stamp)
Physician’s Name ____________________________________________ Physician’s Phone __________
/ Office Address ____________________________________________ (Circle One)
Physician’s Signature ____________________________ M.D. | D.O Date: __________
Adena Sports Medicine Concussion Return to Play Form

Athlete's Name ___________________________________________ Date of Birth: ____________________________

School: Chillicothe HS Team / Sport: Varsity Football

Date of injury: 10/12/12 □ please see attached information

<table>
<thead>
<tr>
<th>Did the athlete have:</th>
<th>(Circle One)</th>
<th>Duration/Resolution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of consciousness or unresponsiveness?</td>
<td>Yes [ ] No</td>
<td>Duration:</td>
</tr>
<tr>
<td>Seizure or convulsive activity?</td>
<td>Yes [ ] No</td>
<td>Duration:</td>
</tr>
<tr>
<td>Balance problems/unsteadiness?</td>
<td>Yes [ ] No</td>
<td>If yes, has this resolved? Yes [ ] No</td>
</tr>
<tr>
<td>Dizziness?</td>
<td>Yes [ ] No</td>
<td>If yes, has this resolved? Yes [ ] No</td>
</tr>
<tr>
<td>Headache?</td>
<td>Yes [ ] No</td>
<td>If yes, has this resolved? Yes [ ] No</td>
</tr>
<tr>
<td>Nausea or vomiting?</td>
<td>Yes [ ] No</td>
<td>If yes, has this resolved? Yes [ ] No</td>
</tr>
<tr>
<td>Emotional instability?</td>
<td>Yes [ ] No</td>
<td>If yes, has this resolved? Yes [ ] No</td>
</tr>
<tr>
<td>Confusion?</td>
<td>Yes [ ] No</td>
<td>If yes, has this resolved? Yes [ ] No</td>
</tr>
<tr>
<td>Difficulty concentrating?</td>
<td>Yes [ ] No</td>
<td>If yes, has this resolved? Yes [ ] No</td>
</tr>
<tr>
<td>Vision Problems?</td>
<td>Yes [ ] No</td>
<td>If yes, has this resolved? Yes [ ] No</td>
</tr>
<tr>
<td>Memory loss after or prior to injury?</td>
<td>Yes [ ] No</td>
<td>If yes, has this resolved? Yes [ ] No</td>
</tr>
<tr>
<td>Other: Glassy eyes</td>
<td>Yes [ ] No</td>
<td>If yes, has this resolved? Yes [ ] No</td>
</tr>
</tbody>
</table>

Athletic Trainer: Andrea Anderson ATC Date: 10/13/12

PHYSICIAN RECOMMENDATIONS: The following are the return to sports recommendations at the present time

☐ Do NOT return to sports practice or competition at this time

☐ May return to sports practice via stepwise protocol under the supervision of the team health care provider

☐ Must return to Physician for final clearance to return to competition

☐ FULL CLEARANCE: May return to full participation in ALL activities (PE and Sports)

☐ Axon computer based concussion testing done [ ] PASS [ ] FAIL Date: ____________

Return to this office on (date/time) ___________________________________________ ☐ No follow-up needed

Additional Comments: ____________________________________________________________

Medical Office Information (Please Print/Stamp)

Physician's Name ___________________________________________ Physician's Phone ________________________

/ Office Address ___________________________________________ (Circle One)

Physician's Signature _______________________________________ M.D. | D.O Date: ____________