

Pediatric Mild Traumatic Brain Injury

Return-to-Play Progression

Criteria

Athletes must meet the following criteria to be considered ready to begin the return-to-play progression:

1. Athletes must be symptom-free.
2. Normal cognitive testing (including baseline comparison if available) and Concussion Symptom Checklist.
3. Completed Return-to-School Progression checklist and remain symptom-free.
4. If computerized concussion testing (i.e., ImpACT™) available, repeat must be performed and reviewed by a concussion specialist. If referred to neuropsychology, evaluation must be at expected levels.
5. No other physical injuries may be present that will prevent them from a successful return to full sports.

Return-to-Play Progression

All steps should be monitored by a certified athletic trainer or coach. If ANY symptoms develop, the athlete should STOP exercising that day and return to the previous step only after 24 hours asymptomatic.

Progression should not be any quicker than one step per 24 hours. The entire sequence will take approximately one week. For athletes with a prolonged recovery, physicians may choose to alter, delay or extend the progression back to play.

- Remain symptom-free for 24 hours without using pain medication
- Light aerobic exercise for 20 minutes (stationary bike, jogging, walking)
- Sport-specific exercise for 30 minutes (soccer foot skills, throwing baseball, shooting and dribbling basketball)
- Noncontact training drills for 30 – 45 minutes and/or progressive resistance training (practice drills that don't put individual at risk for getting head hit – passing/shooting/footwork drills or weight lifting)

AT THIS TIME, IN ACCORDANCE WITH THE OHIO DEPARTMENT OF HEALTH LAW, ATHLETES REQUIRE WRITTEN PERMISSION FROM AN APPROPRIATE HEALTH CARE PROVIDER BEFORE PROGRESSING. IF BASELINE NEUROCOGNITIVE TESTING IS AVAILABLE FOR COMPARISON, A REPEAT SHOULD BE PERFORMED NO LATER THAN THIS STEP WITH NO CONTINUED PROGRESSION UNTIL DEEMED BACK TO BASELINE LEVELS BY AN APPROPRIATE HEALTH CARE PROVIDER.

- Full contact training drills
- Return to play in games allowed

For additional evaluation by the UH Rainbow Babies & Children's Hospital Sports Medicine Team, Pediatric Neurology or Neuropsychology team, please call 216-983-PLAY (216-983-7529).

Concussion Symptom Score Sheet

Name _____

Date of injury _____

Circle the number that indicates how much the symptom bothers the patient

Symptom	Date: ____________ Symptom Rating Scale				Date: ____________ Symptom Rating Scale				Date: ____________ Symptom Rating Scale				Date: ____________ Symptom Rating Scale				Date: ____________ Symptom Rating Scale											
	None	Mild	Mod	Severe	None	Mild	Mod	Severe	None	Mild	Mod	Severe	None	Mild	Mod	Severe	None	Mild	Mod	Severe								
Headache	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Nausea	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Vomiting	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Balance problems	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Dizzy	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Fatigue or tired	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Trouble falling asleep	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Sleeping more than usual	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Sleeping less than usual	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Drowsy (feeling sleepy)	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Eyes sensitive to light	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Visual problems	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Bothered by noise	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Irritable	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Sad	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Nervous	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Feeling more emotional	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Numbness or tingling	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Feeling slowed down	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Feeling mentally "foggy"	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Trouble concentrating	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Trouble with memory	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6
TOTAL SCORE																												

Concussion Symptom Score Sheet

Name _____

Date of injury _____

Circle the number that indicates how much the symptom bothers the patient

Symptom	Date: ____________ Symptom Rating Scale				Date: ____________ Symptom Rating Scale				Date: ____________ Symptom Rating Scale				Date: ____________ Symptom Rating Scale				Date: ____________ Symptom Rating Scale											
	None	Mild	Mod	Severe	None	Mild	Mod	Severe	None	Mild	Mod	Severe	None	Mild	Mod	Severe	None	Mild	Mod	Severe								
Headache	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6
Nausea	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6
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Eyes sensitive to light	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6
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Trouble with memory	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6	0	1	2	3	4	5	6
TOTAL SCORE																												

Mild Traumatic Brain Injury School Recovery Plan

Patient's name _____

Provider's name _____ Date of evaluation _____

Duration of recommendations _____

Please excuse the student from school today for this medical appointment. This student has suffered a mild traumatic brain injury or concussion. Individuals with concussions experience symptoms that often cause them to struggle in the school setting. Please implement the following recommendations to prevent any delay in recovery. The following are suggestions for academic adjustments that are individualized for the student in the school setting. If the patient is improving, and you feel adjustments are no longer necessary, please have the parent/guardian contact the above-named provider to discuss advancing his/her school participation and/or workload.

Attendance

- No school for _____ school day(s)
- May attend school ____ days/week
- Partial days as tolerated
- Partial days as tolerated, advance to full days as symptoms decrease
- Full days as tolerated

Breaks

- Allow breaks during school day if symptoms are worsening (recommend resting 20 – 30 minutes)
- Allow student to go to nurse's office or other quiet area for rest, and may go home if symptoms do not subside
- Acetaminophen _____ (Q4hr) or Ibuprofen _____ (Q6hr w/food) may be given to treat headache

Visual stimuli

- Allow student to wear sunglasses/hat in school
- No screen time (e.g., computers, TV)
- Limited screen time (e.g., computers, TV) as tolerated
- Preprinted notes for class material or a note-taker

Audible stimuli

- Allow lunch in a quiet area with a friend
- Avoid music and/or workshop classes
- Allow student to wear earplugs in school
- Allow five-minute early dismissal to move between classrooms

Workload

- Provide modified versions of assignments, extended time
- Reduce overall amount of make-up work, class work and homework; eliminate all unnecessary make-up work
- Allow additional time to complete assignments
- Allow tutor/counselor/intervention specialist

Testing

- No testing until _____
- Allow additional time to complete tests
- Allow use of notes for tests
- No more than one test per day

Physical activity

- No physical exertion – including athletics, gym or recess
- Walking in gym class only
- Begin return-to-play protocol as outlined on the Return to Play handout

For additional information or questions, call 216-983-PLAY (216-983-7529) or 216-983-HEAD (216-983-4323).