



## England Netball Concussion Policy

### **Introduction**

This document has been developed to provide an evidence-based, best practice guide to assist in the recognition and management of sports related concussion. It is intended for use not only by the Doctors, Physiotherapists and other healthcare professionals who may treat players with concussion but by anyone and everyone involved in the game of Netball including Coaches, Officials, Teachers, Parents and of course the players themselves.

Firstly it is important to appreciate the potentially serious nature of concussion and treat it with respect. Although concussion is not as common in Netball compared to other contact sports, such as Rugby Union, it does occur and anyone involved in the game should be familiar with the basic concept of recognising the symptoms and signs of concussion and removing a player from the court if there is any doubt.

### **‘IF IN DOUBT, SIT THEM OUT’**

The Concussion Recognition Tool version 5 (CRT5) *Appendix 1* supports this message and is intended for use at all levels of Netball, with no medical training required. It highlights the signs and symptoms suggestive of a concussion and can help guide early management when no healthcare professional is present.

Scientific knowledge in the area of sports related concussion is rapidly evolving and as such this document will be continually updated to reflect the changes in guidelines and consensus statements produced from the International Consensus Conferences on Concussion in Sport, most recently held in Berlin in late 2016. Subsequently the document entitled ‘Consensus statement on concussion in sport’ – accessible for free online <http://bjsm.bmj.com/content/51/11/838> - was published. This has led to an update of the England Netball concussion policy in January 2018. It is expected further updates will occur before 31<sup>st</sup> December 2020.

### **What is Concussion and how is it caused?**

Concussion is caused either by a direct or indirect blow to the head, face, neck or elsewhere on the body when there is an impulsive force transmitted up to the head.

Concussion typically results in the rapid onset of temporary impairment of brain function. However in some cases symptoms may only evolve over a period of minutes to hours. Loss of consciousness occurs in less than 15% of concussion cases and is **not** a requirement for diagnosing concussion.

Concussion may result in long term neuropathological changes, but the acute symptoms largely reflect a functional disturbance rather than a structural injury and, as such, no abnormality is seen on standard MRI or CT scans.

The majority of concussions (80-90%) resolve within a 7-10 day period. It is important to recognise that the symptoms of concussion and time frames for recovery can be different and more prolonged in children and adolescents.





### **Why is it important to recognise an episode of Concussion?**

Players who continue to play or return to play with concussive symptoms are at significant risk of:

- Sustaining other injuries (to self, teammates & opposition players) due to poor decision making or reduced reaction time.
- Suffering potentially more serious head injuries, e.g. Second Impact Syndrome.
- Serious injury or death due to an unidentified structural brain injury.
- Potential development of long term neurological deterioration (e.g. Chronic Traumatic Encephalopathy).
- A substantially reduced level of performance.

### **Symptoms and Signs of Concussion**

Concussion can present with a vast array of different signs and symptoms so it is extremely important to maintain a high degree of suspicion when assessing any player following a potentially concussive event. Again it is worth highlighting to sustain a concussion the player does not have to have experienced either a direct head injury or lost consciousness.

Symptoms of concussion can include somatic (e.g. headache), cognitive (e.g. feeling like in a fog), and/or emotional symptoms (e.g. lability). Physical signs include amnesia and there may be behavioural changes such as irritability. Cognitive function may be impaired such as slowed reaction times and there is often associated sleep disturbance e.g. insomnia.


### **Initial assessment of a potentially concussed player**

Any player sustaining a potentially concussive event should be evaluated by a suitably trained healthcare professional that is competent in the assessment and management of sports related concussion and has successfully completed a relevant pitch side trauma course. If there is not such a healthcare professional present it is recommend all players of any age should be removed safely from the court and referred to an NHS Emergency Department for further assessment.

### ***In the setting where an appropriately qualified healthcare professional is present:***

- Initial assessment should include an ABCDE approach with particular approach to ensure there is no risk of an associated Cervical Spine injury.
- Following this if the player displays any signs or symptoms of concussion they should be removed immediately from the field of play and must NOT be allowed to return to play or train again that day.
- Assessment at this point helps to determine if the player is concussed. Concussion is a clinical diagnosis and there is no gold standard test or investigation. Rather a multi modal assessment method including history, neurological examination, balance assessment and neurocognitive assessment should be used. A SCAT5 assessment (Appendix 2) should occur in every athlete






suspected of having concussion. This should be done at rest and within 3 hours of the initial injury. This should take place in a quiet, relaxed atmosphere and not at the courtside.

- Assessment of players under the age of 13 should use the modified Child SCAT5 (Appendix 3). It is advised input from a Doctor with experience of managing sports related concussion is obtained for this age group.
- Both versions of the SCAT5 are for use by healthcare professionals only; for non-healthcare professionals the Concussion Recognition Tool version 5 (CRT5) should be used.
- A player with concussion should not be left alone and be monitored at regular intervals to ensure no change in clinical condition – again it needs to be highlighted that concussion is an evolving injury in the acute stage.
- Due to potential delayed onset of symptoms any player suspected of sustaining a concussive event but who passes the initial SCAT5 and clinical assessment should be subject to a follow up SCAT5 and clinical re-assessment after 24-48hrs to fully exclude an episode of concussion.
- Refer to the Concussion Recognition Tool version 5 (CRT5) or SCAT 5 for red flag signs and symptoms that warrant immediate transfer to an Emergency Department for assessment.
- In Netball there is no current ruling to allow for court side concussion assessment and then return to play if it is deemed that the player is not concussed as exists in other sports (e.g. Head Injury Assessments in Rugby Union). This should not occur – if the player is suspected of having concussion they are simply removed from the field of play and NOT allowed to return to training or playing that day.
- Please note that players can have a normal SCAT5 but can still be diagnosed as having concussion based on clinical assessment by a Doctor. The opposite is not true however - players with an abnormal SCAT5 do have concussion and cannot be overruled by a medical or non-medical opinion.
- In order to determine if a SCAT5 is abnormal this is compared to the players' baseline SCAT5 assessment which should be done for every player at International/NSL level pre-season. Any variation in one or more of the assessment areas (symptom checklist, cognitive assessment and balance assessment) from baseline strongly suggests concussion.
- If baseline information is not available any of the following should be considered as suggestive of concussion on a SCAT5:
  - Symptoms: One or more symptoms in the checklist which would not usually be experienced by the player after playing or training.
  - SAC assessment: Total score 24 or below, Concentration score (digits backwards) 2 or below, Delayed recall 3 or less words.
  - Balance assessment: Tandem test-3 or more errors, single leg stance test 4 or more errors.





## Management of concussion

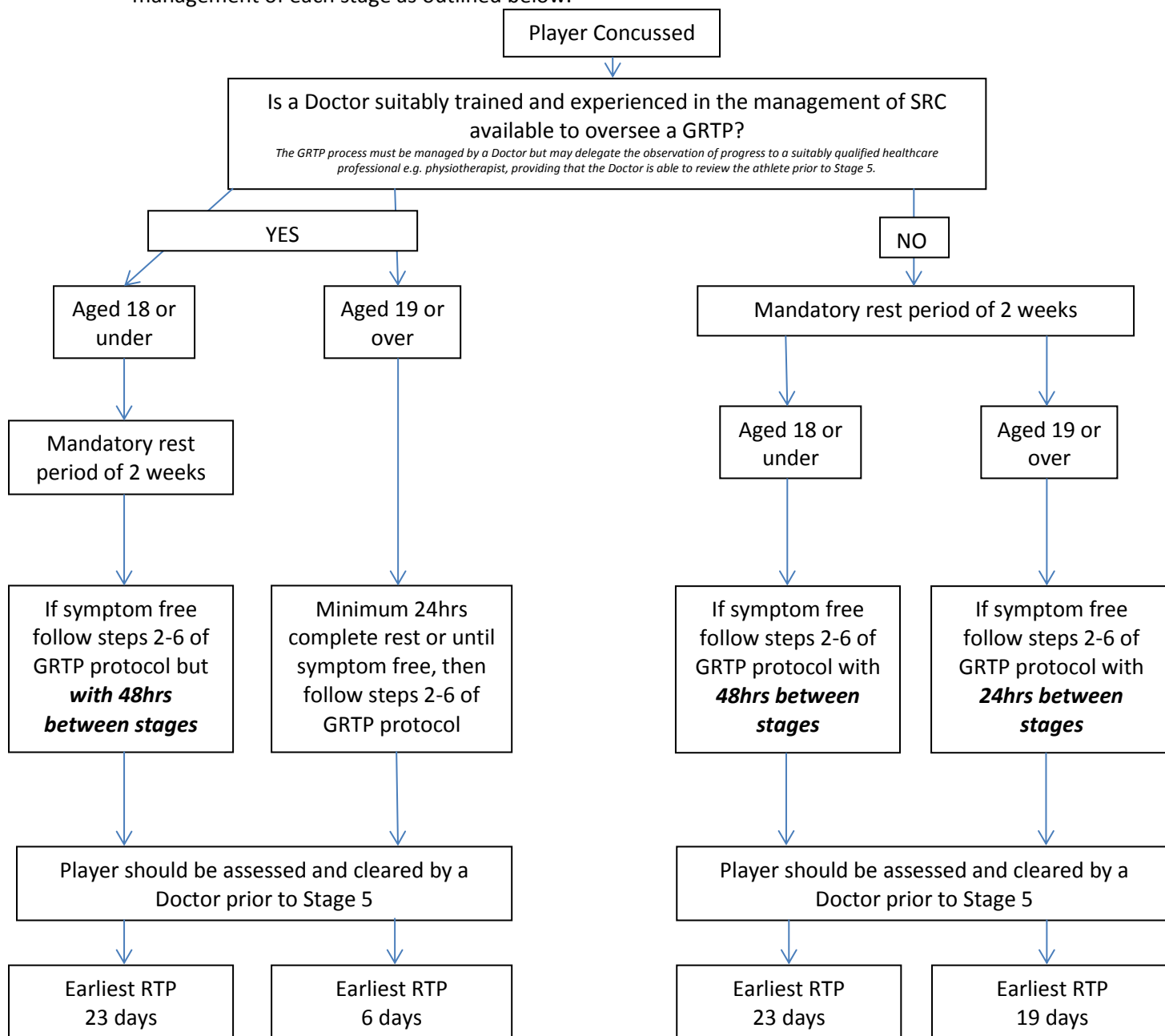
*All players diagnosed with concussion should:*

- Not be left alone and when allowed home must be in the presence of someone suitable to monitor their symptoms.
- Be given written advice and a contact detail for the assessing healthcare professional (this is provided using the last page of the SCAT5 assessment).
- Be given advice as per the SCAT5 for symptoms and signs to watch for and when to seek help.
- Rest completely from physical exercise/exertion as well as any cognitive exertion – this includes excessive use of mobile phones, tablets, watching TVs and academic work – until symptoms have resolved and they are medically cleared.
- Not take sleeping tablets, Aspirin, Anti-inflammatory medication or sedating analgesia. Not drink alcohol. Not drive until symptoms have resolved.
- Not train or play again until medically cleared.



## Graduated Return to Play (G RTP)

There is different advice for the use of a G RTP Protocol and mandatory stand down periods depending both on age of the player and presence of a Healthcare professional to oversee management of each stage as outlined below:



- If a player develops symptoms during the G RTP protocol they should be returned to the previous stage and the protocol re-started when they are symptom free.
- All players should be assessed by a Doctor with experience in the management of concussion prior to entering Stage 5.
- Presence of any of the following risk factors should prompt referral to a Doctor or service with experience in managing concussion (e.g. Sport & Exercise Medicine Consultant/Concussion Clinic):
  - Second concussion within a 12 month period
  - History of multiple concussions (>3)
  - Unusual presentations (e.g. associated migraines or prominent balance issues)
  - Recovery that takes longer than 10 days

### England Netball Graduated Return to Play Protocol

Rehabilitation Stage	Functional exercise	Objective
1. Symptom limited activity	Physical & cognitive rest Daily activities that do not provoke symptoms	Gradual reintroduction of work/school activities Full recovery of all symptoms
2. Light aerobic exercise	Steady pace static bike with HR <70% maximum, 30 minutes. No resistance training.	Increase in HR. Must remain symptom free for following 24hrs.
3. Netball specific exercise	Predicted change of direction drills on court	Add predicted movement. Must complete and remain symptom free for following 24hrs.
4. Uncontested training	Unpredicted but uncontested training drills. Can add resistance exercise.	Exercise, co-ordination and cognitive load. Must complete and remain symptom free for following 24hrs.
5. Full training	Following medical clearance by a Doctor experienced in concussion management can participate in normal training unrestricted	Restore confidence and readiness to perform. Must complete and remain symptom free for following 24hrs.
6. Return to matchplay	Perform at or above previous level	Must complete and remain symptom free thereafter.

#### Specific areas to highlight:

##### **Children & Adolescents (Aged 18 years and under)**

Concussion in this age group often presents with differing symptoms and signs and recovery can be more prolonged. It is vital that the correct mandatory rest period of 2 weeks following an episode of concussion is respected and the time taken for each stage of the GRTP is at least 48hrs. All players in this age group must be cleared by a healthcare professional with experience in the management of concussion before stage 5 of the GRTP protocol.

##### **Academic and Non-academic work**

It is advised that academic work (e.g. school, college, university) and non-academic work is ceased following a concussion until the symptoms have resolved and stage 2 of the GRTP process has begun. During the GRTP it is also recommended that academic and non-academic work is reduced until completion of the process. This is in order to allow the brain to fully rest and recover following an episode of concussion.

##### **Persisting symptoms (>10 days)**

More prolonged recovery occurs in 10-20% of concussions. In this event it is recommended referral to a Doctor with expertise in the management of sports related concussion e.g. a Consultant in Sport & Exercise Medicine or a specialist Concussion Clinic such as the Manchester Institute of





Health & Performance Concussion Clinic <http://www.mihp.co.uk/health/specialist-clinics/>.

### **Concussion modifiers**

In the following situations it is recommended a cautious approach is taken to concussion management and further expert advice from a medical professional experienced in concussion is taken if there is any doubt.

- Increased number, duration or severity of symptoms.
- Prolonged loss of consciousness (>1 minute) or amnesia.
- Any convulsive episode associated with concussion.
- History of repeated concussions (>3) or recent previous concussion.
- Trend towards less impact causing concussions or longer recovery period.
- Age 18 and under.
- History of Migraine, Mental Health disorder, Attention Deficit Hyperactivity Disorder, Learning Disabilities, Dyslexia, Sleep disorders.
- Prescribed anti-coagulants or psychoactive medication.
- Dangerous style of play or other high risk sport participation.

This document has been produced as a best practice guide for the sport of Netball in England. It should not be used as a replacement for adequate medical training, knowledge and expertise in the assessment and management of sports related concussion and does not replace thorough clinical assessment. As highlighted previously, at any stage if there is any clinical uncertainty this should warrant referral to a healthcare professional with experience in sports related concussion for review.

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January 2018

Next review date: No later than 31<sup>st</sup> December 2020

This document is only a guide and not intended as a clinical practice guideline or legal standard of care. Individual treatment will depend on the facts and circumstances specific to each individual case.



## CONCUSSION RECOGNITION TOOL 5 ©

To help identify concussion in children, adolescents and adults



### RECOGNISE & REMOVE

Head impacts can be associated with serious and potentially fatal brain injuries. The Concussion Recognition Tool 5 (CRT5) is to be used for the identification of suspected concussion. It is not designed to diagnose concussion.

#### STEP 1: RED FLAGS — CALL AN AMBULANCE

If there is concern after an injury including whether ANY of the following signs are observed or complaints are reported then the player should be safely and immediately removed from play/game/activity. If no licensed healthcare professional is available, call an ambulance for urgent medical assessment:

- Neck pain or tenderness
- Double vision
- Weakness or tingling/burning in arms or legs
- Severe or increasing headache
- Seizure or convulsion
- Loss of consciousness
- Deteriorating conscious state
- Vomiting
- Increasingly restless, agitated or combative

#### Remember:

- In all cases, the basic principles of first aid (danger, response, airway, breathing, circulation) should be followed.
- Do not attempt to move the player (other than required for airway support) unless trained to do so.
- Do not remove a helmet or any other equipment unless trained to do so safely.
- Assessment for a spinal cord injury is critical.

If there are no Red Flags, identification of possible concussion should proceed to the following steps:

#### STEP 2: OBSERVABLE SIGNS

Visual clues that suggest possible concussion include:

- Lying motionless on the playing surface
- Slow to get up after a direct or indirect hit to the head
- Disorientation or confusion, or an inability to respond appropriately to questions
- Balance, gait difficulties, motor incoordination, stumbling, slow laboured movements
- Blank or vacant look
- Facial injury after head trauma

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### STEP 3: SYMPTOMS

- Headache
- "Pressure in head"
- Balance problems
- Nausea or vomiting
- Drowsiness
- Dizziness
- Blurred vision
- Sensitivity to light
- Sensitivity to noise
- Fatigue or low energy
- "Don't feel right"
- More emotional
- More Irritable
- Sadness
- Nervous or anxious
- Neck Pain
- Feeling like "in a fog"
- Difficulty concentrating
- Difficulty remembering
- Feeling slowed down

### STEP 4: MEMORY ASSESSMENT

(IN ATHLETES OLDER THAN 12 YEARS)

Failure to answer any of these questions (modified appropriately for each sport) correctly may suggest a concussion:

- "What venue are we at today?"
- "Which half is it now?"
- "Who scored last in this game?"
- "What team did you play last week/game?"
- "Did your team win the last game?"

### Athletes with suspected concussion should:

- Not be left alone initially (at least for the first 1-2 hours).
- Not drink alcohol.
- Not use recreational/ prescription drugs.
- Not be sent home by themselves. They need to be with a responsible adult.
- Not drive a motor vehicle until cleared to do so by a healthcare professional.

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**ANY ATHLETE WITH A SUSPECTED CONCUSSION SHOULD BE IMMEDIATELY REMOVED FROM PRACTICE OR PLAY AND SHOULD NOT RETURN TO ACTIVITY UNTIL ASSESSED MEDICALLY, EVEN IF THE SYMPTOMS RESOLVE**

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## Concussion recognition tool 5©

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# SCAT5<sup>®</sup>

## SPORT CONCUSSION ASSESSMENT TOOL – 5TH EDITION

DEVELOPED BY THE CONCUSSION IN SPORT GROUP  
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FEI

### Patient details

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Address: \_\_\_\_\_

ID number: \_\_\_\_\_

Examiner: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Time: \_\_\_\_\_

## WHAT IS THE SCAT5?

**The SCAT5 is a standardized tool for evaluating concussions designed for use by physicians and licensed healthcare professionals<sup>1</sup>. The SCAT5 cannot be performed correctly in less than 10 minutes.**

If you are not a physician or licensed healthcare professional, please use the Concussion Recognition Tool 5 (CRT5). The SCAT5 is to be used for evaluating athletes aged 13 years and older. For children aged 12 years or younger, please use the Child SCAT5.

Preseason SCAT5 baseline testing can be useful for interpreting post-injury test scores, but is not required for that purpose. Detailed instructions for use of the SCAT5 are provided on page 7. Please read through these instructions carefully before testing the athlete. Brief verbal instructions for each test are given in italics. The only equipment required for the tester is a watch or timer.

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## Recognise and Remove

A head impact by either a direct blow or indirect transmission of force can be associated with a serious and potentially fatal brain injury. If there are significant concerns, including any of the red flags listed in Box 1, then activation of emergency procedures and urgent transport to the nearest hospital should be arranged.

### Key points

- Any athlete with suspected concussion should be REMOVED FROM PLAY, medically assessed and monitored for deterioration. No athlete diagnosed with concussion should be returned to play on the day of injury.
- If an athlete is suspected of having a concussion and medical personnel are not immediately available, the athlete should be referred to a medical facility for urgent assessment.
- Athletes with suspected concussion should not drink alcohol, use recreational drugs and should not drive a motor vehicle until cleared to do so by a medical professional.
- Concussion signs and symptoms evolve over time and it is important to consider repeat evaluation in the assessment of concussion.
- The diagnosis of a concussion is a clinical judgment, made by a medical professional. The SCAT5 should NOT be used by itself to make, or exclude, the diagnosis of concussion. An athlete may have a concussion even if their SCAT5 is "normal".

### Remember:

- The basic principles of first aid (danger, response, airway, breathing, circulation) should be followed.
- Do not attempt to move the athlete (other than that required for airway management) unless trained to do so.
- Assessment for a spinal cord injury is a critical part of the initial on-field assessment.
- Do not remove a helmet or any other equipment unless trained to do so safely.

## IMMEDIATE OR ON-FIELD ASSESSMENT

The following elements should be assessed for all athletes who are suspected of having a concussion prior to proceeding to the neurocognitive assessment and ideally should be done on-field after the first first aid / emergency care priorities are completed.

If any of the "Red Flags" or observable signs are noted after a direct or indirect blow to the head, the athlete should be immediately and safely removed from participation and evaluated by a physician or licensed healthcare professional.

Consideration of transportation to a medical facility should be at the discretion of the physician or licensed healthcare professional.

The GCS is important as a standard measure for all patients and can be done serially if necessary in the event of deterioration in conscious state. The Maddocks questions and cervical spine exam are critical steps of the immediate assessment; however, these do not need to be done serially.

### STEP 1: RED FLAGS

#### RED FLAGS:

- Neck pain or tenderness
- Double vision
- Weakness or tingling/ burning in arms or legs
- Severe or increasing headache
- Seizure or convulsion
- Loss of consciousness
- Deteriorating conscious state
- Vomiting
- Increasingly restless, agitated or combative

### STEP 2: OBSERVABLE SIGNS

Witnessed  Observed on Video

	Y	N
Lying motionless on the playing surface	Y	N
Balance / gait difficulties / motor incoordination: stumbling, slow / laboured movements	Y	N
Disorientation or confusion, or an inability to respond appropriately to questions	Y	N
Blank or vacant look	Y	N
Facial injury after head trauma	Y	N

### STEP 3: MEMORY ASSESSMENT MADDOCKS QUESTIONS<sup>2</sup>

"I am going to ask you a few questions, please listen carefully and give your best effort. First, tell me what happened?"

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Mark Y for correct answer / N for incorrect

	Y	N
What venue are we at today?	Y	N
Which half is it now?	Y	N
Who scored last in this match?	Y	N
What team did you play last week / game?	Y	N
Did your team win the last game?	Y	N

Note: Appropriate sport-specific questions may be substituted.

Name: \_\_\_\_\_  
 DOB: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 ID number: \_\_\_\_\_  
 Examiner: \_\_\_\_\_  
 Date: \_\_\_\_\_

### STEP 4: EXAMINATION

#### GLASGOW COMA SCALE (GCS)<sup>3</sup>

Time of assessment			
Date of assessment			
<b>Best eye response (E)</b>			
No eye opening	1	1	1
Eye opening in response to pain	2	2	2
Eye opening to speech	3	3	3
Eyes opening spontaneously	4	4	4
<b>Best verbal response (V)</b>			
No verbal response	1	1	1
Incomprehensible sounds	2	2	2
Inappropriate words	3	3	3
Confused	4	4	4
Oriented	5	5	5
<b>Best motor response (M)</b>			
No motor response	1	1	1
Extension to pain	2	2	2
Abnormal flexion to pain	3	3	3
Flexion / Withdrawal to pain	4	4	4
Localizes to pain	5	5	5
Obeys commands	6	6	6
<b>Glasgow Coma score (E + V + M)</b>			

### CERVICAL SPINE ASSESSMENT

Does the athlete report that their neck is pain free at rest?	Y	N
If there is <b>NO neck pain at rest</b> , does the athlete have a full range of ACTIVE pain free movement?	Y	N
Is the limb strength and sensation normal?	Y	N

**In a patient who is not lucid or fully conscious, a cervical spine injury should be assumed until proven otherwise.**

## OFFICE OR OFF-FIELD ASSESSMENT

Please note that the neurocognitive assessment should be done in a distraction-free environment with the athlete in a resting state.

### STEP 1: ATHLETE BACKGROUND

Sport / team / school: \_\_\_\_\_

Date / time of injury: \_\_\_\_\_

Years of education completed: \_\_\_\_\_

Age: \_\_\_\_\_

Gender: M / F / Other

Dominant hand: left / neither / right

How many diagnosed concussions has the athlete had in the past?: \_\_\_\_\_

When was the most recent concussion?: \_\_\_\_\_

How long was the recovery (time to being cleared to play) from the most recent concussion?: \_\_\_\_\_ (days)

#### Has the athlete ever been:

	Yes	No
Hospitalized for a head injury?		
Diagnosed / treated for headache disorder or migraines?		
Diagnosed with a learning disability / dyslexia?		
Diagnosed with ADD / ADHD?		
Diagnosed with depression, anxiety or other psychiatric disorder?		

Current medications? If yes, please list:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Address: \_\_\_\_\_

ID number: \_\_\_\_\_

Examiner: \_\_\_\_\_

Date: \_\_\_\_\_

2

### STEP 2: SYMPTOM EVALUATION

The athlete should be given the symptom form and asked to read this instruction paragraph out loud then complete the symptom scale. For the baseline assessment, the athlete should rate his/her symptoms based on how he/she typically feels and for the post injury assessment the athlete should rate their symptoms at this point in time.

Please Check:  Baseline  Post-Injury

Please hand the form to the athlete

	none	mild	moderate	severe			
Headache	0	1	2	3	4	5	6
"Pressure in head"	0	1	2	3	4	5	6
Neck Pain	0	1	2	3	4	5	6
Nausea or vomiting	0	1	2	3	4	5	6
Dizziness	0	1	2	3	4	5	6
Blurred vision	0	1	2	3	4	5	6
Balance problems	0	1	2	3	4	5	6
Sensitivity to light	0	1	2	3	4	5	6
Sensitivity to noise	0	1	2	3	4	5	6
Feeling slowed down	0	1	2	3	4	5	6
Feeling like "in a fog"	0	1	2	3	4	5	6
"Don't feel right"	0	1	2	3	4	5	6
Difficulty concentrating	0	1	2	3	4	5	6
Difficulty remembering	0	1	2	3	4	5	6
Fatigue or low energy	0	1	2	3	4	5	6
Confusion	0	1	2	3	4	5	6
Drowsiness	0	1	2	3	4	5	6
More emotional	0	1	2	3	4	5	6
Irritability	0	1	2	3	4	5	6
Sadness	0	1	2	3	4	5	6
Nervous or Anxious	0	1	2	3	4	5	6
Trouble falling asleep (if applicable)	0	1	2	3	4	5	6

Total number of symptoms: \_\_\_\_\_ of 22

Symptom severity score: \_\_\_\_\_ of 132

Do your symptoms get worse with physical activity? Y N

Do your symptoms get worse with mental activity? Y N

If 100% is feeling perfectly normal, what percent of normal do you feel?

If not 100%, why?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please hand form back to examiner

### STEP 3: COGNITIVE SCREENING

#### Standardised Assessment of Concussion (SAC)<sup>4</sup>

#### ORIENTATION

What month is it?	0	1
What is the date today?	0	1
What is the day of the week?	0	1
What year is it?	0	1
What time is it right now? (within 1 hour)	0	1
<b>Orientation score</b>	<b>of 5</b>	

#### IMMEDIATE MEMORY

The Immediate Memory component can be completed using the traditional 5-word per trial list or optionally using 10-words per trial to minimise any ceiling effect. All 3 trials must be administered irrespective of the number correct on the first trial. Administer at the rate of one word per second.

**Please choose EITHER the 5 or 10 word list groups and circle the specific word list chosen for this test.**

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

List	Alternate 5 word lists					Score (of 5)		
						Trial 1	Trial 2	Trial 3
A	Finger	Penny	Blanket	Lemon	Insect			
B	Candle	Paper	Sugar	Sandwich	Wagon			
C	Baby	Monkey	Perfume	Sunset	Iron			
D	Elbow	Apple	Carpet	Saddle	Bubble			
E	Jacket	Arrow	Pepper	Cotton	Movie			
F	Dollar	Honey	Mirror	Saddle	Anchor			
<b>Immediate Memory Score</b>						<b>of 15</b>		
<b>Time that last trial was completed</b>								

List	Alternate 10 word lists					Score (of 10)		
						Trial 1	Trial 2	Trial 3
G	Finger	Penny	Blanket	Lemon	Insect			
	Candle	Paper	Sugar	Sandwich	Wagon			
H	Baby	Monkey	Perfume	Sunset	Iron			
	Elbow	Apple	Carpet	Saddle	Bubble			
I	Jacket	Arrow	Pepper	Cotton	Movie			
	Dollar	Honey	Mirror	Saddle	Anchor			
<b>Immediate Memory Score</b>						<b>of 30</b>		
<b>Time that last trial was completed</b>								

Name: \_\_\_\_\_  
 DOB: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 ID number: \_\_\_\_\_  
 Examiner: \_\_\_\_\_  
 Date: \_\_\_\_\_

#### CONCENTRATION

#### DIGITS BACKWARDS

Please circle the Digit list chosen (A, B, C, D, E, F). Administer at the rate of one digit per second reading DOWN the selected column.

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

Concentration Number Lists (circle one)					
List A	List B	List C			
4-9-3	5-2-6	1-4-2	Y	N	0
6-2-9	4-1-5	6-5-8	Y	N	1
3-8-1-4	1-7-9-5	6-8-3-1	Y	N	0
3-2-7-9	4-9-6-8	3-4-8-1	Y	N	1
6-2-9-7-1	4-8-5-2-7	4-9-1-5-3	Y	N	0
1-5-2-8-6	6-1-8-4-3	6-8-2-5-1	Y	N	1
7-1-8-4-6-2	8-3-1-9-6-4	3-7-6-5-1-9	Y	N	0
5-3-9-1-4-8	7-2-4-8-5-6	9-2-6-5-1-4	Y	N	1
List D	List E	List F			
7-8-2	3-8-2	2-7-1	Y	N	0
9-2-6	5-1-8	4-7-9	Y	N	1
4-1-8-3	2-7-9-3	1-6-8-3	Y	N	0
9-7-2-3	2-1-6-9	3-9-2-4	Y	N	1
1-7-9-2-6	4-1-8-6-9	2-4-7-5-8	Y	N	0
4-1-7-5-2	9-4-1-7-5	8-3-9-6-4	Y	N	1
2-6-4-8-1-7	6-9-7-3-8-2	5-8-6-2-4-9	Y	N	0
8-4-1-9-3-5	4-2-7-9-3-8	3-1-7-8-2-6	Y	N	1
<b>Digits Score:</b>					<b>of 4</b>

#### MONTHS IN REVERSE ORDER

*Now tell me the months of the year in reverse order. Start with the last month and go backward. So you'll say December, November. Go ahead.*

Dec - Nov - Oct - Sept - Aug - Jul - Jun - May - Apr - Mar - Feb - Jan	0	1
<b>Months Score</b>	<b>of 1</b>	
<b>Concentration Total Score (Digits + Months)</b>	<b>of 5</b>	

4

### STEP 4: NEUROLOGICAL SCREEN

See the instruction sheet (page 7) for details of test administration and scoring of the tests.

Can the patient read aloud (e.g. symptom check-list) and follow instructions without difficulty?	Y	N
Does the patient have a full range of pain-free PASSIVE cervical spine movement?	Y	N
Without moving their head or neck, can the patient look side-to-side and up-and-down without double vision?	Y	N
Can the patient perform the finger nose coordination test normally?	Y	N
Can the patient perform tandem gait normally?	Y	N

### BALANCE EXAMINATION

#### Modified Balance Error Scoring System (mBESS) testing<sup>5</sup>

Which foot was tested (i.e. which is the non-dominant foot)  Left  Right

Testing surface (hard floor, field, etc.) \_\_\_\_\_

Footwear (shoes, barefoot, braces, tape, etc.) \_\_\_\_\_

Condition	Errors
<b>Double leg stance</b>	_____ of 10
<b>Single leg stance (non-dominant foot)</b>	_____ of 10
<b>Tandem stance (non-dominant foot at the back)</b>	_____ of 10
<b>Total Errors</b>	_____ of 30

Name: \_\_\_\_\_  
 DOB: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 ID number: \_\_\_\_\_  
 Examiner: \_\_\_\_\_  
 Date: \_\_\_\_\_

5

### STEP 5: DELAYED RECALL:

The delayed recall should be performed after 5 minutes have elapsed since the end of the Immediate Recall section. Score 1 pt. for each correct response.

*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.*

Time Started \_\_\_\_\_

Please record each word correctly recalled. Total score equals number of words recalled.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Total number of words recalled accurately: \_\_\_\_\_ of 5 or \_\_\_\_\_ of 10

6

### STEP 6: DECISION

Domain	Date & time of assessment:		
Symptom number (of 22)			
Symptom severity score (of 132)			
Orientation (of 5)			
Immediate memory	_____ of 15 _____ of 30	_____ of 15 _____ of 30	_____ of 15 _____ of 30
Concentration (of 5)			
Neuro exam	Normal Abnormal	Normal Abnormal	Normal Abnormal
Balance errors (of 30)			
Delayed Recall	_____ of 5 _____ of 10	_____ of 5 _____ of 10	_____ of 5 _____ of 10

Date and time of injury: \_\_\_\_\_

If the athlete is known to you prior to their injury, are they different from their usual self?

Yes  No  Unsure  Not Applicable

(If different, describe why in the clinical notes section)

Concussion Diagnosed?

Yes  No  Unsure  Not Applicable

If re-testing, has the athlete improved?

Yes  No  Unsure  Not Applicable

**I am a physician or licensed healthcare professional and I have personally administered or supervised the administration of this SCAT5.**

Signature: \_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Registration number (if applicable): \_\_\_\_\_

Date: \_\_\_\_\_

**SCORING ON THE SCAT5 SHOULD NOT BE USED AS A STAND-ALONE METHOD TO DIAGNOSE CONCUSSION, MEASURE RECOVERY OR MAKE DECISIONS ABOUT AN ATHLETE'S READINESS TO RETURN TO COMPETITION AFTER CONCUSSION.**

## CLINICAL NOTES:

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Name: \_\_\_\_\_  
 DOB: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 ID number: \_\_\_\_\_  
 Examiner: \_\_\_\_\_  
 Date: \_\_\_\_\_



## CONCUSSION INJURY ADVICE

(To be given to the person monitoring the concussed athlete)

This patient has received an injury to the head. A careful medical examination has been carried out and no sign of any serious complications has been found. Recovery time is variable across individuals and the patient will need monitoring for a further period by a responsible adult. Your treating physician will provide guidance as to this timeframe.

**If you notice any change in behaviour, vomiting, worsening headache, double vision or excessive drowsiness, please telephone your doctor or the nearest hospital emergency department immediately.**

Other important points:

**Initial rest: Limit physical activity to routine daily activities (avoid exercise, training, sports) and limit activities such as school, work, and screen time to a level that does not worsen symptoms.**

- 1) Avoid alcohol
- 2) Avoid prescription or non-prescription drugs without medical supervision. Specifically:
  - a) Avoid sleeping tablets
  - b) Do not use aspirin, anti-inflammatory medication or stronger pain medications such as narcotics
- 3) Do not drive until cleared by a healthcare professional.
- 4) Return to play/sport requires clearance by a healthcare professional.

Clinic phone number: \_\_\_\_\_

Patient's name: \_\_\_\_\_

Date / time of injury: \_\_\_\_\_

Date / time of medical review: \_\_\_\_\_

Healthcare Provider: \_\_\_\_\_

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**Contact details or stamp**

## INSTRUCTIONS

Words in *Italics* throughout the SCAT5 are the instructions given to the athlete by the clinician

### Symptom Scale

The time frame for symptoms should be based on the type of test being administered. At baseline it is advantageous to assess how an athlete "typically" feels whereas during the acute/post-acute stage it is best to ask how the athlete feels at the time of testing.

The symptom scale should be completed by the athlete, not by the examiner. In situations where the symptom scale is being completed after exercise, it should be done in a resting state, generally by approximating his/her resting heart rate.

For total number of symptoms, maximum possible is 22 except immediately post injury, if sleep item is omitted, which then creates a maximum of 21.

For Symptom severity score, add all scores in table, maximum possible is 22 x 6 = 132, except immediately post injury if sleep item is omitted, which then creates a maximum of 21x6=126.

### Immediate Memory

The Immediate Memory component can be completed using the traditional 5-word per trial list or, optionally, using 10-words per trial. The literature suggests that the Immediate Memory has a notable ceiling effect when a 5-word list is used. In settings where this ceiling is prominent, the examiner may wish to make the task more difficult by incorporating two 5-word groups for a total of 10 words per trial. In this case, the maximum score per trial is 10 with a total trial maximum of 30.

Choose one of the word lists (either 5 or 10). Then perform 3 trials of immediate memory using this list.

Complete all 3 trials regardless of score on previous trials.

*"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."* The words must be read at a rate of one word per second.

Trials 2 & 3 MUST be completed regardless of score on trial 1 & 2.

Trials 2 & 3:

*"I am going to repeat the same list again. Repeat back as many words as you can remember in any order, even if you said the word before."*

Score 1 pt. for each correct response. Total score equals sum across all 3 trials. Do NOT inform the athlete that delayed recall will be tested.

### Concentration

#### Digits backward

Choose one column of digits from lists A, B, C, D, E or F and administer those digits as follows:

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

Begin with first 3 digit string.

If correct, circle "Y" for correct and go to next string length. If incorrect, circle "N" for the first string length and read trial 2 in the same string length. One point possible for each string length. Stop after incorrect on both trials (2 N's) in a string length. The digits should be read at the rate of one per second.

#### Months in reverse order

*"Now tell me the months of the year in reverse order. Start with the last month and go backward. So you'll say December, November ... Go ahead"*

1 pt. for entire sequence correct

#### Delayed Recall

The delayed recall should be performed after 5 minutes have elapsed since the end of the Immediate Recall section.

*"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."*

Score 1 pt. for each correct response

### Modified Balance Error Scoring System (mBESS)<sup>5</sup> testing

This balance testing is based on a modified version of the Balance Error Scoring System (BESS)<sup>5</sup>. A timing device is required for this testing.

Each of 20-second trial/stance is scored by counting the number of errors. The examiner will begin counting errors only after the athlete has assumed the proper start position. The modified BESS is calculated by adding one error point for each error during the three 20-second tests. The maximum number of errors for any single condition is 10. If the athlete commits multiple errors simultaneously, only

one error is recorded but the athlete should quickly return to the testing position, and counting should resume once the athlete is set. Athletes that are unable to maintain the testing procedure for a minimum of five seconds at the start are assigned the highest possible score, ten, for that testing condition.

OPTION: For further assessment, the same 3 stances can be performed on a surface of medium density foam (e.g., approximately 50cm x 40cm x 6cm).

#### Balance testing – types of errors

- |                                 |   |   |
|---------------------------------|---|---|
| 1. Hands lifted off iliac crest | 3. Step, stumble, or fall                 | 5. Lifting forefoot or heel               |
| 2. Opening eyes                 | 4. Moving hip into > 30 degrees abduction | 6. Remaining out of test position > 5 sec |

*"I am now going to test your balance. Please take your shoes off (if applicable), roll up your pant legs above ankle (if applicable), and remove any ankle taping (if applicable). This test will consist of three twenty second tests with different stances."*

(a) Double leg stance:

*"The first stance is standing with your feet together with your hands on your hips and with your eyes closed. You should try to maintain stability in that position for 20 seconds. I will be counting the number of times you move out of this position. I will start timing when you are set and have closed your eyes."*

(b) Single leg stance:

*"If you were to kick a ball, which foot would you use? [This will be the dominant foot] Now stand on your non-dominant foot. The dominant leg should be held in approximately 30 degrees of hip flexion and 45 degrees of knee flexion. Again, you should try to maintain stability for 20 seconds with your hands on your hips and your eyes closed. I will be counting the number of times you move out of this position. If you stumble out of this position, open your eyes and return to the start position and continue balancing. I will start timing when you are set and have closed your eyes."*

(c) Tandem stance:

*"Now stand heel-to-toe with your non-dominant foot in back. Your weight should be evenly distributed across both feet. Again, you should try to maintain stability for 20 seconds with your hands on your hips and your eyes closed. I will be counting the number of times you move out of this position. If you stumble out of this position, open your eyes and return to the start position and continue balancing. I will start timing when you are set and have closed your eyes."*

### Tandem Gait

Participants are instructed to stand with their feet together behind a starting line (the test is best done with footwear removed). Then, they walk in a forward direction as quickly and as accurately as possible along a 38mm wide (sports tape), 3 metre line with an alternate foot heel-to-toe gait ensuring that they approximate their heel and toe on each step. Once they cross the end of the 3m line, they turn 180 degrees and return to the starting point using the same gait. Athletes fail the test if they step off the line, have a separation between their heel and toe, or if they touch or grab the examiner or an object.

### Finger to Nose

*"I am going to test your coordination now. Please sit comfortably on the chair with your eyes open and your arm (either right or left) outstretched (shoulder flexed to 90 degrees and elbow and fingers extended), pointing in front of you. When I give a start signal, I would like you to perform five successive finger to nose repetitions using your index finger to touch the tip of the nose, and then return to the starting position, as quickly and as accurately as possible."*

### References

1. McCrory et al. Consensus Statement On Concussion In Sport – The 5th International Conference On Concussion In Sport Held In Berlin, October 2016. British Journal of Sports Medicine 2017 (available at [www.bjsm.bmj.com](http://www.bjsm.bmj.com))
2. Maddocks, DL; Dicker, GD; Saling, MM. The assessment of orientation following concussion in athletes. Clinical Journal of Sport Medicine 1995; 5: 32-33
3. Jennett, B., Bond, M. Assessment of outcome after severe brain damage: a practical scale. Lancet 1975; i: 480-484
4. McCrea M. Standardized mental status testing of acute concussion. Clinical Journal of Sport Medicine. 2001; 11: 176-181
5. Guskiewicz KM. Assessment of postural stability following sport-related concussion. Current Sports Medicine Reports. 2003; 2: 24-30



## CONCUSSION INFORMATION

**Any athlete suspected of having a concussion should be removed from play and seek medical evaluation.**

### Signs to watch for

Problems could arise over the first 24-48 hours. The athlete should not be left alone and must go to a hospital at once if they experience:

- Worsening headache
- Drowsiness or inability to be awakened
- Inability to recognize people or places
- Repeated vomiting
- Unusual behaviour or confusion or irritable
- Seizures (arms and legs jerk uncontrollably)
- Weakness or numbness in arms or legs
- Unsteadiness on their feet.
- Slurred speech

**Consult your physician or licensed healthcare professional after a suspected concussion. Remember, it is better to be safe.**

### Rest & Rehabilitation

After a concussion, the athlete should have physical rest and relative cognitive rest for a few days to allow their symptoms to improve. In most cases, after no more than a few days of rest, the athlete should gradually increase their daily activity level as long as their symptoms do not worsen. Once the athlete is able to complete their usual daily activities without concussion-related symptoms, the second step of the return to play/sport progression can be started. The athlete should not return to play/sport until their concussion-related symptoms have resolved and the athlete has successfully returned to full school/learning activities.

When returning to play/sport, the athlete should follow a stepwise, **medically managed exercise progression, with increasing amounts of exercise.** For example:

### Graduated Return to Sport Strategy

Exercise step	Functional exercise at each step	Goal of each step
1. Symptom-limited activity	Daily activities that do not provoke symptoms.	Gradual reintroduction of work/school activities.
2. Light aerobic exercise	Walking or stationary cycling at slow to medium pace. No resistance training.	Increase heart rate.
3. Sport-specific exercise	Running or skating drills. No head impact activities.	Add movement.
4. Non-contact training drills	Harder training drills, e.g., passing drills. May start progressive resistance training.	Exercise, coordination, and increased thinking.
5. Full contact practice	Following medical clearance, participate in normal training activities.	Restore confidence and assess functional skills by coaching staff.
6. Return to play/sport	Normal game play.	

In this example, it would be typical to have 24 hours (or longer) for each step of the progression. If any symptoms worsen while exercising, the athlete should go back to the previous step. Resistance training should be added only in the later stages (Stage 3 or 4 at the earliest).

**Written clearance should be provided by a healthcare professional before return to play/sport as directed by local laws and regulations.**

### Graduated Return to School Strategy

Concussion may affect the ability to learn at school. The athlete may need to miss a few days of school after a concussion. When going back to school, some athletes may need to go back gradually and may need to have some changes made to their schedule so that concussion symptoms do not get worse. If a particular activity makes symptoms worse, then the athlete should stop that activity and rest until symptoms get better. To make sure that the athlete can get back to school without problems, it is important that the healthcare provider, parents, caregivers and teachers talk to each other so that everyone knows what the plan is for the athlete to go back to school.

**Note: If mental activity does not cause any symptoms, the athlete may be able to skip step 2 and return to school part-time before doing school activities at home first.**

Mental Activity	Activity at each step	Goal of each step
1. Daily activities that do not give the athlete symptoms	Typical activities that the athlete does during the day as long as they do not increase symptoms (e.g. reading, texting, screen time). Start with 5-15 minutes at a time and gradually build up.	Gradual return to typical activities.
2. School activities	Homework, reading or other cognitive activities outside of the classroom.	Increase tolerance to cognitive work.
3. Return to school part-time	Gradual introduction of school-work. May need to start with a partial school day or with increased breaks during the day.	Increase academic activities.
4. Return to school full-time	Gradually progress school activities until a full day can be tolerated.	Return to full academic activities and catch up on missed work.

If the athlete continues to have symptoms with mental activity, some other accommodations that can help with return to school may include:

- Starting school later, only going for half days, or going only to certain classes
- More time to finish assignments/tests
- Quiet room to finish assignments/tests
- Not going to noisy areas like the cafeteria, assembly halls, sporting events, music class, shop class, etc.
- Taking lots of breaks during class, homework, tests
- No more than one exam/day
- Shorter assignments
- Repetition/memory cues
- Use of a student helper/tutor
- Reassurance from teachers that the child will be supported while getting better

**The athlete should not go back to sports until they are back to school/learning, without symptoms getting significantly worse and no longer needing any changes to their schedule.**



## Sport concussion assessment tool - 5th edition

*Br J Sports Med* published online April 26, 2017

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Updated information and services can be found at:  
<http://bjsm.bmj.com/content/early/2017/04/26/bjsports-2017-097506S>  
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# Child SCAT5<sup>®</sup>

**SPORT CONCUSSION ASSESSMENT TOOL**  
FOR CHILDREN AGES 5 TO 12 YEARS  
FOR USE BY MEDICAL PROFESSIONALS ONLY

supported by



## Patient details

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Address: \_\_\_\_\_

ID number: \_\_\_\_\_

Examiner: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Time: \_\_\_\_\_

## WHAT IS THE CHILD SCAT5?

**The Child SCAT5 is a standardized tool for evaluating concussions designed for use by physicians and licensed healthcare professionals<sup>1</sup>.**

If you are not a physician or licensed healthcare professional, please use the Concussion Recognition Tool 5 (CRT5). The Child SCAT5 is to be used for evaluating Children aged 5 to 12 years. For athletes aged 13 years and older, please use the SCAT5.

Preseason Child SCAT5 baseline testing can be useful for interpreting post-injury test scores, but not required for that purpose. Detailed instructions for use of the Child SCAT5 are provided on page 7. Please read through these instructions carefully before testing the athlete. Brief verbal instructions for each test are given in italics. The only equipment required for the tester is a watch or timer.

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## Recognise and Remove

A head impact by either a direct blow or indirect transmission of force can be associated with a serious and potentially fatal brain injury. If there are significant concerns, including any of the red flags listed in Box 1, then activation of emergency procedures and urgent transport to the nearest hospital should be arranged.

## Key points

- Any athlete with suspected concussion should be **REMOVED FROM PLAY**, medically assessed and monitored for deterioration. No athlete diagnosed with concussion should be returned to play on the day of injury.
- If the child is suspected of having a concussion and medical personnel are not immediately available, the child should be referred to a medical facility for urgent assessment.
- Concussion signs and symptoms evolve over time and it is important to consider repeat evaluation in the assessment of concussion.
- The diagnosis of a concussion is a clinical judgment, made by a medical professional. The Child SCAT5 should **NOT** be used by itself to make, or exclude, the diagnosis of concussion. An athlete may have a concussion even if their Child SCAT5 is "normal".

## Remember:

- The basic principles of first aid (danger, response, airway, breathing, circulation) should be followed.
- Do not attempt to move the athlete (other than that required for airway management) unless trained to do so.
- Assessment for a spinal cord injury is a critical part of the initial on-field assessment.
- Do not remove a helmet or any other equipment unless trained to do so safely.

1

## IMMEDIATE OR ON-FIELD ASSESSMENT

The following elements should be assessed for all athletes who are suspected of having a concussion prior to proceeding to the neurocognitive assessment and ideally should be done on-field after the first first aid / emergency care priorities are completed.

If any of the "Red Flags" or observable signs are noted after a direct or indirect blow to the head, the athlete should be immediately and safely removed from participation and evaluated by a physician or licensed healthcare professional.

Consideration of transportation to a medical facility should be at the discretion of the physician or licensed healthcare professional.

The GCS is important as a standard measure for all patients and can be done serially if necessary in the event of deterioration in conscious state. The cervical spine exam is a critical step of the immediate assessment, however, it does not need to be done serially.

### STEP 1: RED FLAGS

#### RED FLAGS:

- Neck pain or tenderness
- Double vision
- Weakness or tingling/ burning in arms or legs
- Severe or increasing headache
- Seizure or convulsion
- Loss of consciousness
- Deteriorating conscious state
- Vomiting
- Increasingly restless, agitated or combative

### STEP 2: OBSERVABLE SIGNS

Witnessed  Observed on Video

Lying motionless on the playing surface	Y	N
Balance / gait difficulties / motor incoordination: stumbling, slow / laboured movements	Y	N
Disorientation or confusion, or an inability to respond appropriately to questions	Y	N
Blank or vacant look	Y	N
Facial injury after head trauma	Y	N

### STEP 3: EXAMINATION

#### GLASGOW COMA SCALE (GCS)<sup>2</sup>

Time of assessment			
Date of assessment			

#### Best eye response (E)

No eye opening	1	1	1
Eye opening in response to pain	2	2	2
Eye opening to speech	3	3	3
Eyes opening spontaneously	4	4	4

#### Best verbal response (V)

No verbal response	1	1	1
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Name: \_\_\_\_\_  
 DOB: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 ID number: \_\_\_\_\_  
 Examiner: \_\_\_\_\_  
 Date: \_\_\_\_\_

Incomprehensible sounds	2	2	2
Inappropriate words	3	3	3
Confused	4	4	4
Oriented	5	5	5
<b>Best motor response (M)</b>			
No motor response	1	1	1
Extension to pain	2	2	2
Abnormal flexion to pain	3	3	3
Flexion / Withdrawal to pain	4	4	4
Localizes to pain	5	5	5
Obeys commands	6	6	6
<b>Glasgow Coma score (E + V + M)</b>			

### CERVICAL SPINE ASSESSMENT

Does the athlete report that their neck is pain free at rest?	Y	N
If there is <b>NO neck pain at rest</b> , does the athlete have a full range of ACTIVE pain free movement?	Y	N
Is the limb strength and sensation normal?	Y	N

**In a patient who is not lucid or fully conscious, a cervical spine injury should be assumed until proven otherwise.**

### OFFICE OR OFF-FIELD ASSESSMENT STEP 1: ATHLETE BACKGROUND

Please note that the neurocognitive assessment should be done in a distraction-free environment with the athlete in a resting state.

Sport / team / school: \_\_\_\_\_

Date / time of injury: \_\_\_\_\_

Years of education completed: \_\_\_\_\_

Age: \_\_\_\_\_

Gender: M / F / Other

Dominant hand: left / neither / right

How many diagnosed concussions has the athlete had in the past?: \_\_\_\_\_

When was the most recent concussion?: \_\_\_\_\_

How long was the recovery (time to being cleared to play) from the most recent concussion?: \_\_\_\_\_ (days)

#### Has the athlete ever been:

Hospitalized for a head injury? Yes No

Diagnosed / treated for headache disorder or migraines? Yes No

Diagnosed with a learning disability / dyslexia? Yes No

Diagnosed with ADD / ADHD? Yes No

Diagnosed with depression, anxiety or other psychiatric disorder? Yes No

Current medications? If yes, please list: \_\_\_\_\_

## STEP 2: SYMPTOM EVALUATION

The athlete should be given the symptom form and asked to read this instruction paragraph out loud then complete the symptom scale. For the baseline assessment, the athlete should rate his/her symptoms based on how he/she typically feels and for the post injury assessment the athlete should rate their symptoms at this point in time.

To be done in a resting state

Please Check:  Baseline  Post-Injury

2

### Child Report<sup>3</sup>

	Not at all/ Never	A little/ Rarely	Somewhat/ Sometimes	A lot/ Often
I have headaches	0	1	2	3
I feel dizzy	0	1	2	3
I feel like the room is spinning	0	1	2	3
I feel like I'm going to faint	0	1	2	3
Things are blurry when I look at them	0	1	2	3
I see double	0	1	2	3
I feel sick to my stomach	0	1	2	3
My neck hurts	0	1	2	3
I get tired a lot	0	1	2	3
I get tired easily	0	1	2	3
I have trouble paying attention	0	1	2	3
I get distracted easily	0	1	2	3
I have a hard time concentrating	0	1	2	3
I have problems remembering what people tell me	0	1	2	3
I have problems following directions	0	1	2	3
I daydream too much	0	1	2	3
I get confused	0	1	2	3
I forget things	0	1	2	3
I have problems finishing things	0	1	2	3
I have trouble figuring things out	0	1	2	3
It's hard for me to learn new things	0	1	2	3
Total number of symptoms:				of 21
Symptom severity score:				of 63
Do the symptoms get worse with physical activity?			Y	N
Do the symptoms get worse with trying to think?			Y	N

### Overall rating for child to answer:

	Very bad	Very good
On a scale of 0 to 10 (where 10 is normal), how do you feel now?	0 1 2 3 4 5 6 7 8 9 10	

If not 10, in what way do you feel different?:

\_\_\_\_\_

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Address: \_\_\_\_\_

ID number: \_\_\_\_\_

Examiner: \_\_\_\_\_

Date: \_\_\_\_\_

### Parent Report

#### The child:

	Not at all/ Never	A little/ Rarely	Somewhat/ Sometimes	A lot/ Often
has headaches	0	1	2	3
feels dizzy	0	1	2	3
has a feeling that the room is spinning	0	1	2	3
feels faint	0	1	2	3
has blurred vision	0	1	2	3
has double vision	0	1	2	3
experiences nausea	0	1	2	3
has a sore neck	0	1	2	3
gets tired a lot	0	1	2	3
gets tired easily	0	1	2	3
has trouble sustaining attention	0	1	2	3
is easily distracted	0	1	2	3
has difficulty concentrating	0	1	2	3
has problems remembering what he/she is told	0	1	2	3
has difficulty following directions	0	1	2	3
tends to daydream	0	1	2	3
gets confused	0	1	2	3
is forgetful	0	1	2	3
has difficulty completing tasks	0	1	2	3
has poor problem solving skills	0	1	2	3
has problems learning	0	1	2	3
Total number of symptoms:				of 21
Symptom severity score:				of 63
Do the symptoms get worse with physical activity?			Y	N
Do the symptoms get worse with mental activity?			Y	N

### Overall rating for parent/teacher/coach/carer to answer

On a scale of 0 to 100% (where 100% is normal), how would you rate the child now?

\_\_\_\_\_

If not 100%, in what way does the child seem different?

\_\_\_\_\_

### STEP 3: COGNITIVE SCREENING

Standardized Assessment of Concussion - Child Version (SAC-C)<sup>4</sup>

#### IMMEDIATE MEMORY

The Immediate Memory component can be completed using the traditional 5-word per trial list or optionally using 10-words per trial to minimise any ceiling effect. All 3 trials must be administered irrespective of the number correct on the first trial. Administer at the rate of one word per second.

Please choose EITHER the 5 or 10 word list groups and circle the specific word list chosen for this test.

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

List	Alternate 5 word lists					Score (of 5)		
						Trial 1	Trial 2	Trial 3
A	Finger	Penny	Blanket	Lemon	Insect			
B	Candle	Paper	Sugar	Sandwich	Wagon			
C	Baby	Monkey	Perfume	Sunset	Iron			
D	Elbow	Apple	Carpet	Saddle	Bubble			
E	Jacket	Arrow	Pepper	Cotton	Movie			
F	Dollar	Honey	Mirror	Saddle	Anchor			
<b>Immediate Memory Score</b>						of 15		
<b>Time that last trial was completed</b>								

List	Alternate 10 word lists					Score (of 10)		
						Trial 1	Trial 2	Trial 3
G	Finger	Penny	Blanket	Lemon	Insect			
	Candle	Paper	Sugar	Sandwich	Wagon			
H	Baby	Monkey	Perfume	Sunset	Iron			
	Elbow	Apple	Carpet	Saddle	Bubble			
I	Jacket	Arrow	Pepper	Cotton	Movie			
	Dollar	Honey	Mirror	Saddle	Anchor			
<b>Immediate Memory Score</b>						of 30		
<b>Time that last trial was completed</b>								

Name: \_\_\_\_\_  
 DOB: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 ID number: \_\_\_\_\_  
 Examiner: \_\_\_\_\_  
 Date: \_\_\_\_\_

### CONCENTRATION

#### DIGITS BACKWARDS

Please circle the Digit list chosen (A, B, C, D, E, F). Administer at the rate of one digit per second reading DOWN the selected column.

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

Concentration Number Lists (circle one)					
List A	List B	List C			
5-2	4-1	4-9	Y	N	0
4-1	9-4	6-2	Y	N	1
4-9-3	5-2-6	1-4-2	Y	N	0
6-2-9	4-1-5	6-5-8	Y	N	1
3-8-1-4	1-7-9-5	6-8-3-1	Y	N	0
3-2-7-9	4-9-6-8	3-4-8-1	Y	N	1
6-2-9-7-1	4-8-5-2-7	4-9-1-5-3	Y	N	0
1-5-2-8-6	6-1-8-4-3	6-8-2-5-1	Y	N	1
7-1-8-4-6-2	8-3-1-9-6-4	3-7-6-5-1-9	Y	N	0
5-3-9-1-4-8	7-2-4-8-5-6	9-2-6-5-1-4	Y	N	1
List D	List E	List F			
2-7	9-2	7-8	Y	N	0
5-9	6-1	5-1	Y	N	1
7-8-2	3-8-2	2-7-1	Y	N	0
9-2-6	5-1-8	4-7-9	Y	N	1
4-1-8-3	2-7-9-3	1-6-8-3	Y	N	0
9-7-2-3	2-1-6-9-	3-9-2-4	Y	N	1
1-7-9-2-6	4-1-8-6-9	2-4-7-5-8	Y	N	0
4-1-7-5-2	9-4-1-7-5	8-3-9-6-4	Y	N	1
2-6-4-8-1-7	6-9-7-3-8-2	5-8-6-2-4-9	Y	N	0
8-4-1-9-3-5	4-2-7-3-9-8	3-1-7-8-2-6	Y	N	1
<b>Digits Score:</b>					of 5

#### DAYS IN REVERSE ORDER

*Now tell me the days of the week in reverse order. Start with the last day and go backward. So you'll say Sunday, Saturday. Go ahead.*

Sunday - Saturday - Friday - Thursday - Wednesday - Tuesday - Monday	0 1
<b>Days Score</b>	of 1
<b>Concentration Total Score (Digits + Days)</b>	of 6

4

### STEP 4: NEUROLOGICAL SCREEN

See the instruction sheet (page 7) for details of test administration and scoring of the tests.

Can the patient read aloud (e.g. symptom checklist) and follow instructions without difficulty?	Y	N
Does the patient have a full range of pain-free PASSIVE cervical spine movement?	Y	N
Without moving their head or neck, can the patient look side-to-side and up-and-down without double vision?	Y	N
Can the patient perform the finger nose coordination test normally?	Y	N
Can the patient perform tandem gait normally?	Y	N

### BALANCE EXAMINATION

#### Modified Balance Error Scoring System (BESS) testing<sup>5</sup>

Which foot was tested  Left (i.e. which is the non-dominant foot)  Right

Testing surface (hard floor, field, etc.) \_\_\_\_\_

Footwear (shoes, barefoot, braces, tape, etc.) \_\_\_\_\_

Condition	Errors
<b>Double leg stance</b>	_____ of 10
<b>Single leg stance (non-dominant foot, 10-12 y/o only)</b>	_____ of 10
<b>Tandem stance (non-dominant foot at back)</b>	_____ of 10
<b>Total Errors</b>	5-9 y/o _____ of 20    10-12 y/o _____ of 30

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Address: \_\_\_\_\_

ID number: \_\_\_\_\_

Examiner: \_\_\_\_\_

Date: \_\_\_\_\_

5

### STEP 5: DELAYED RECALL:

The delayed recall should be performed after 5 minutes have elapsed since the end of the Immediate Recall section. Score 1 pt. for each correct response.

*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.*

Time Started \_\_\_\_\_

Please record each word correctly recalled. Total score equals number of words recalled.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Total number of words recalled accurately: \_\_\_\_\_ of 5 or \_\_\_\_\_ of 10

6

### STEP 6: DECISION

Domain	Date & time of assessment:		
Symptom number Child report (of 21) Parent report (of 21)			
Symptom severity score Child report (of 63) Parent report (of 63)			
Immediate memory	_____ of 15 _____ of 30	_____ of 15 _____ of 30	_____ of 15 _____ of 30
Concentration (of 6)			
Neuro exam	Normal Abnormal	Normal Abnormal	Normal Abnormal
Balance errors (5-9 y/o of 20) (10-12 y/o of 30)			
Delayed Recall	_____ of 5 _____ of 10	_____ of 5 _____ of 10	_____ of 5 _____ of 10

Date and time of injury: \_\_\_\_\_

If the athlete is known to you prior to their injury, are they different from their usual self?

Yes  No  Unsure  Not Applicable

(If different, describe why in the clinical notes section)

Concussion Diagnosed?

Yes  No  Unsure  Not Applicable

If re-testing, has the athlete improved?

Yes  No  Unsure  Not Applicable

**I am a physician or licensed healthcare professional and I have personally administered or supervised the administration of this Child SCAT5.**

Signature: \_\_\_\_\_

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Registration number (if applicable): \_\_\_\_\_

Date: \_\_\_\_\_

**SCORING ON THE CHILD SCAT5 SHOULD NOT BE USED AS A STAND-ALONE METHOD TO DIAGNOSE CONCUSSION, MEASURE RECOVERY OR MAKE DECISIONS ABOUT AN ATHLETE'S READINESS TO RETURN TO COMPETITION AFTER CONCUSSION.**



For the Neurological Screen (page 5), if the child cannot read, ask him/her to describe what they see in this picture.

Name: \_\_\_\_\_  
 DOB: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 ID number: \_\_\_\_\_  
 Examiner: \_\_\_\_\_  
 Date: \_\_\_\_\_

### CLINICAL NOTES:

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### Concussion injury advice for the child and parents/caregivers

**(To be given to the person monitoring the concussed child)**

This child has had an injury to the head and needs to be carefully watched for the next 24 hours by a responsible adult.

**If you notice any change in behavior, vomiting, dizziness, worsening headache, double vision or excessive drowsiness, please call an ambulance to take the child to hospital immediately.**

Other important points:

Following concussion, the child should rest for at least 24 hours.

- The child should not use a computer, internet or play video games if these activities make symptoms worse.
- The child should not be given any medications, including pain killers, unless prescribed by a medical doctor.
- The child should not go back to school until symptoms are improving.
- The child should not go back to sport or play until a doctor gives permission.

Clinic phone number: \_\_\_\_\_

Patient's name: \_\_\_\_\_

Date / time of injury: \_\_\_\_\_

Date / time of medical review: \_\_\_\_\_

Healthcare Provider: \_\_\_\_\_

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Contact details or stamp



## INSTRUCTIONS

Words in *Italics* throughout the Child SCAT5 are the instructions given to the athlete by the clinician

### Symptom Scale

In situations where the symptom scale is being completed after exercise, it should still be done in a resting state, at least 10 minutes post exercise.

At Baseline	On the day of injury	On all subsequent days
<ul style="list-style-type: none"> <li>The child is to complete the Child Report, according to how he/she feels today, and</li> <li>The parent/carer is to complete the Parent Report according to how the child has been over the previous week.</li> </ul>	<ul style="list-style-type: none"> <li>The child is to complete the Child Report, according to how he/she feels now.</li> <li>If the parent is present, and has had time to assess the child on the day of injury, the parent completes the Parent Report according to how the child appears now.</li> </ul>	<ul style="list-style-type: none"> <li>The child is to complete the Child Report, according to how he/she feels today, and</li> <li>The parent/carer is to complete the Parent Report according to how the child has been over the previous 24 hours.</li> </ul>

For Total number of symptoms, maximum possible is 21

For Symptom severity score, add all scores in table, maximum possible is 21 x 3 = 63

### Standardized Assessment of Concussion Child Version (SAC-C)

#### Immediate Memory

Choose one of the 5-word lists. Then perform 3 trials of immediate memory using this list.

Complete all 3 trials regardless of score on previous trials.

*"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."* The words must be read at a rate of one word per second.

OPTION: The literature suggests that the Immediate Memory has a notable ceiling effect when a 5-word list is used. (In younger children, use the 5-word list). In settings where this ceiling is prominent the examiner may wish to make the task more difficult by incorporating two 5-word groups for a total of 10 words per trial. In this case the maximum score per trial is 10 with a total trial maximum of 30.

Trials 2 & 3 MUST be completed regardless of score on trial 1 & 2.

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

Score 1 pt. for each correct response. Total score equals sum across all 3 trials. Do NOT inform the athlete that delayed recall will be tested.

#### Concentration

##### Digits backward

Choose one column only, from List A, B, C, D, E or F, and administer those digits as follows:

*"I am going to read you some numbers and when I am done, you say them back to me backwards, in reverse order of how I read them to you. For example, if I say 7-1, you would say 1-7."*

If correct, circle "Y" for correct and go to next string length. If incorrect, circle "N" for the first string length and read trial 2 in the same string length. One point possible for each string length. Stop after incorrect on both trials (2 N's) in a string length. The digits should be read at the rate of one per second.

##### Days of the week in reverse order

*"Now tell me the days of the week in reverse order. Start with Sunday and go backward. So you'll say Sunday, Saturday ... Go ahead"*

1 pt. for entire sequence correct

##### Delayed Recall

The delayed recall should be performed after at least 5 minutes have elapsed since the end of the Immediate Recall section.

*"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.

#### Neurological Screen

##### Reading

The child is asked to read a paragraph of text from the instructions in the Child SCAT5. For children who can not read, they are asked to describe what they see in a photograph or picture, such as that on page 6 of the Child SCAT5.

##### Modified Balance Error Scoring System (mBESS)<sup>5</sup> testing

*These instructions are to be read by the person administering the Child SCAT5, and each balance task should be demonstrated to the child. The child should then be asked to copy what the examiner demonstrated.*

Each of 20-second trial/stance is scored by counting the number of errors. The This balance testing is based on a modified version of the Balance Error Scoring System (BESS)<sup>5</sup>.

A stopwatch or watch with a second hand is required for this testing.

*"I am now going to test your balance. Please take your shoes off, roll up your pants above your ankle (if applicable), and remove any ankle taping (if applicable). This test will consist of two different parts."*

OPTION: For further assessment, the same 3 stances can be performed on a surface of medium density foam (e.g., approximately 50cm x 40cm x 6cm).

##### (a) Double leg stance:

*The first stance is standing with the feet together with hands on hips and with eyes closed. The child should try to maintain stability in that position for 20 seconds. You should inform the child that you will be counting the number of times the child moves out of this position. You should start timing when the child is set and the eyes are closed.*

##### (b) Tandem stance:

*Instruct or show the child how to stand heel-to-toe with the non-dominant foot in the back. Weight should be evenly distributed across both feet. Again, the child should try to maintain stability for 20 seconds with hands on hips and eyes closed. You should inform the child that you will be counting the number of times the child moves out of this position. If the child stumbles out of this position, instruct him/her to open the eyes and return to the start position and continue balancing. You should start timing when the child is set and the eyes are closed.*

##### (c) Single leg stance (10-12 year olds only):

*"If you were to kick a ball, which foot would you use? [This will be the dominant foot] Now stand on your other foot. You should bend your other leg and hold it up (show the child). Again, try to stay in that position for 20 seconds with your hands on your hips and your eyes closed. I will be counting the number of times you move out of this position. If you move out of this position, open your eyes and return to the start position and keep balancing. I will start timing when you are set and have closed your eyes."*

### Balance testing – types of errors

- |                                 |   |   |
|---------------------------------|---|---|
| 1. Hands lifted off iliac crest | 3. Step, stumble, or fall                 | 5. Lifting forefoot or heel               |
| 2. Opening eyes                 | 4. Moving hip into > 30 degrees abduction | 6. Remaining out of test position > 5 sec |

Each of the 20-second trials is scored by counting the errors, or deviations from the proper stance, accumulated by the child. The examiner will begin counting errors only after the child has assumed the proper start position. The modified BESS is calculated by adding one error point for each error during the 20-second tests. The maximum total number of errors for any single condition is 10. If a child commits multiple errors simultaneously, only one error is recorded but the child should quickly return to the testing position, and counting should resume once subject is set. Children who are unable to maintain the testing procedure for a minimum of five seconds at the start are assigned the highest possible score, ten, for that testing condition.

### Tandem Gait

Instruction for the examiner - Demonstrate the following to the child:

*The child is instructed to stand with their feet together behind a starting line (the test is best done with footwear removed). Then, they walk in a forward direction as quickly and as accurately as possible along a 38mm wide (sports tape), 3 metre line with an alternate foot heel-to-toe gait ensuring that they approximate their heel and toe on each step. Once they cross the end of the 3m line, they turn 180 degrees and return to the starting point using the same gait. Children fail the test if they step off the line, have a separation between their heel and toe, or if they touch or grab the examiner or an object.*

### Finger to Nose

The tester should demonstrate it to the child.

*"I am going to test your coordination now. Please sit comfortably on the chair with your eyes open and your arm (either right or left) outstretched (shoulder flexed to 90 degrees and elbow and fingers extended). When I give a start signal, I would like you to perform five successive finger to nose repetitions using your index finger to touch the tip of the nose as quickly and as accurately as possible."*

Scoring: 5 correct repetitions in < 4 seconds = 1

Note for testers: Children fail the test if they do not touch their nose, do not fully extend their elbow or do not perform five repetitions.

### References

- McCrory et al. Consensus Statement On Concussion In Sport – The 5th International Conference On Concussion In Sport Held In Berlin, October 2016. British Journal of Sports Medicine 2017 (available at [www.bjsm.bmj.com](http://www.bjsm.bmj.com))
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- Ayr, L.K., Yeates, K.O., Taylor, H.G., Brown, M. Dimensions of postconcussive symptoms in children with mild traumatic brain injuries. Journal of the International Neuropsychological Society. 2009; 15:19-30
- McCrea M. Standardized mental status testing of acute concussion. Clinical Journal of Sports Medicine. 2001; 11: 176-181
- Guskiewicz KM. Assessment of postural stability following sport-related concussion. Current Sports Medicine Reports. 2003; 2: 24-30

## CONCUSSION INFORMATION

**If you think you or a teammate has a concussion, tell your coach/trainer/parent right away so that you can be taken out of the game. You or your teammate should be seen by a doctor as soon as possible. YOU OR YOUR TEAMMATE SHOULD NOT GO BACK TO PLAY/SPORT THAT DAY.**

### Signs to watch for

Problems can happen over the first 24-48 hours. You or your teammate should not be left alone and must go to a hospital right away if any of the following happens:

- New headache, or headache gets worse
- Neck pain that gets worse
- Becomes sleepy/drowsy or can't be woken up
- Cannot recognise people or places
- Feeling sick to your stomach or vomiting
- Acting weird/strange, seems/feels confused, or is irritable
- Has any seizures (arms and/or legs jerk uncontrollably)
- Has weakness, numbness or tingling (arms, legs or face)
- Is unsteady walking or standing
- Talking is slurred
- Cannot understand what someone is saying or directions

**Consult your physician or licensed healthcare professional after a suspected concussion. Remember, it is better to be safe.**

### Graduated Return to Sport Strategy

After a concussion, the child should rest physically and mentally for a few days to allow symptoms to get better. In most cases, after a few days of rest, they can gradually increase their daily activity level as long as symptoms don't get worse. Once they are able to do their usual daily activities without symptoms, the child should gradually increase exercise in steps, guided by the healthcare professional (see below).

**The athlete should not return to play/sport the day of injury.**

**NOTE: An initial period of a few days of both cognitive ("thinking") and physical rest is recommended before beginning the Return to Sport progression.**

Exercise step	Functional exercise at each step	Goal of each step
1. Symptom-limited activity	Daily activities that do not provoke symptoms.	Gradual reintroduction of work/school activities.
2. Light aerobic exercise	Walking or stationary cycling at slow to medium pace. No resistance training.	Increase heart rate.
3. Sport-specific exercise	Running or skating drills. No head impact activities.	Add movement.
4. Non-contact training drills	Harder training drills, e.g., passing drills. May start progressive resistance training.	Exercise, coordination, and increased thinking.
5. Full contact practice	Following medical clearance, participate in normal training activities.	Restore confidence and assess functional skills by coaching staff.
6. Return to play/sport	Normal game play.	

There should be at least 24 hours (or longer) for each step of the progression. If any symptoms worsen while exercising, the athlete should go back to the previous step. Resistance training should be added only in the later stages (Stage 3 or 4 at the earliest). The athlete should not return to sport until the concussion symptoms have gone, they have successfully returned to full school/learning activities, and the healthcare professional has given the child written permission to return to sport.

**If the child has symptoms for more than a month, they should ask to be referred to a healthcare professional who is an expert in the management of concussion.**

### Graduated Return to School Strategy

Concussion may affect the ability to learn at school. The child may need to miss a few days of school after a concussion, but the child's doctor should help them get back to school after a few days. When going back to school, some children may need to go back gradually and may need to have some changes made to their schedule so that concussion symptoms don't get a lot worse. If a particular activity makes symptoms a lot worse, then the child should stop that activity and rest until symptoms get better. To make sure that the child can get back to school without problems, it is important that the health care provider, parents/caregivers and teachers talk to each other so that everyone knows what the plan is for the child to go back to school.

**Note: If mental activity does not cause any symptoms, the child may be able to return to school part-time without doing school activities at home first.**

Mental Activity	Activity at each step	Goal of each step
1. Daily activities that do not give the child symptoms	Typical activities that the child does during the day as long as they do not increase symptoms (e.g. reading, texting, screen time). Start with 5-15 minutes at a time and gradually build up.	Gradual return to typical activities.
2. School activities	Homework, reading or other cognitive activities outside of the classroom.	Increase tolerance to cognitive work.
3. Return to school part-time	Gradual introduction of school-work. May need to start with a partial school day or with increased breaks during the day.	Increase academic activities.
4. Return to school full-time	Gradually progress school activities until a full day can be tolerated.	Return to full academic activities and catch up on missed work.

If the child continues to have symptoms with mental activity, some other things that can be done to help with return to school may include:

- Starting school later, only going for half days, or going only to certain classes
- Taking lots of breaks during class, homework, tests
- More time to finish assignments/tests
- No more than one exam/day
- Quiet room to finish assignments/tests
- Shorter assignments
- Not going to noisy areas like the cafeteria, assembly halls, sporting events, music class, shop class, etc.
- Repetition/memory cues
- Use of a student helper/tutor
- Reassurance from teachers that the child will be supported while getting better

**The child should not go back to sports until they are back to school/learning, without symptoms getting significantly worse and no longer needing any changes to their schedule.**



## Sport concussion assessment tool for childrens ages 5 to 12 years

*Br J Sports Med* published online April 26, 2017

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Updated information and services can be found at:  
<http://bjsm.bmj.com/content/early/2017/04/26/bjsports-2017-097492c/hildscat5.citation>

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