The Hawaii State Department of Education (DOE) and the Athletic Health Care Trainers’ (AHCT) program have instituted a Concussion Management Program (CMP) to ensure student athletes return to athletic participation safely. CMP has aligned the AHCT program with the National Athletic Trainers’ Association Position Statement, 2004¹; the Consensus Statement on Concussion in Sport, 2009²; and the National Federation of State High School Association (NFHS) Concussion Guidelines, 2009³. The National Athletic Trainers’ Association Position Statement, Consensus Statement on Concussion in Sport, and the NFHS Association Concussion Guidelines were developed by physicians, neuropsychologists, and AHCTs trained in concussion management. The NFHS Association established a new rule in the fall of 2010, “any player who shows signs, symptoms or behaviors associated with a concussion must be removed from the game and shall not return to play until cleared by an appropriate health-care professional.”⁴

To comply with the NFHS Association rule change and national guidelines, the DOE and AHCT program have instituted the following guidelines for all student athletes participating in collision and contact sports. All ninth and eleventh grade student athletes participating in collision and contact sports along with tenth and twelfth grade student athletes participating in collision and contact sports for the first time will be administered baseline assessments (described below) which will provide the high school AHCT and the student athlete’s primary care physician with objective information to compare pre-and-post injury.

- Graded Symptom Checklist baseline assessment
- Cognitive status baseline assessment (Immediate Post-Concussion Assessment and Cognitive Test (ImPACT) or Standard Assessment of Concussion (SAC))
- Postural Stability baseline assessment

A student athlete with a possible concussion, will receive two forms: (1) Graded Symptom Checklist for Concussed Athlete (GSC List) and (2) Medical Referral Form for Concussed Athlete. The GSC List form provides your child’s symptoms at the time of injury. It also includes signs and symptoms to watch for and recovery recommendations. The medical referral form provides information for your child’s physician regarding his/her head injury and recommendations for return to activity. After a student athlete takes the cognitive status assessments, the AHCT will collaborate with the student athlete’s physician and/or a neuropsychologist to determine if the student athlete is ready to start a Return to Activity Plan (see below). This team approach ensures the health and safety of each concussed student athlete.

**Return to Activity Plan (RAP) or Return to Play (RTP):**

**Step 1** Complete cognitive rest. This may include staying home from school or limiting school hours and study for several days which would be determined by a physician or AHCT and supported by school administration. Activities requiring concentration and attention may worsen symptoms and delay recovery.

**Step 2** Return to school full time.

**Steps 3-7** Will be supervised by the high school AHCT. *(Each step is separated by a minimum of at least 24 hours.)*

**Step 3** Light exercise. This step cannot begin until student athlete is cleared by the treating physician for further activity. At this point, the student athlete may begin walking or riding a stationary bike.

**Step 4** Running in the gym or on the field.

**Step 5** Non-contact training drills in full equipment. Weight training can begin.

**Step 6** Full contact practice or training.

**Step 7** Play in game.
The AHCT program will continually monitor its CMP to ensure the health and safety of Hawaii’s student athletes. To assist the AHCT program in its CMP monitoring, the DOE will be conducting a study to ensure CMP quality.

By signing below, you acknowledge receipt of information about the DOE’s CMP and the signs and symptoms of a concussion.

(Parent/Guardian or Adult Student Signature)   (Date)

(Student Athlete Signature)   (Date)

Concussion Management Study
(Voluntary)

Participation in this school year’s Concussion Management Study is strictly voluntary and your child will not be penalized if he/she elects not to participate. By agreeing to participate in this study, your student athlete’s concussion data will be included in the study. Concussed student athlete’s injury will be managed whether he/she participates or not in this study. Personal identification information will not be disclosed and will be destroyed at the end of the study.

I, ___________________________, the parent/guardian of ___________________________,
(Parent/Guardian)   (Name of Student Athlete)
☐ Agree to allow my student athlete to participate in school year __________ Concussion Management Study.

☐ Do not agree to allow my student athlete to participate in school year __________ Concussion Management Study.

(Parent/Guardian or Adult Student Signature)   (Date)

(Student Athlete Signature)   (Date)

References:
Hawaii State Department of Education  
PHYSICAL EXAMINATION FOR ATHLETES

Student’s Name ____________________________ M/F _______ Date of Birth _______ / _______ / _______ Grade _______
(Print)  Last __________ First __________ MI _______  Home Phone ____________________________ Student Resides With ____________
Address __________________________________________ Street No.  City __________ Zip Code _______
Fall Sport ____________________________ Winter Sport ____________________________ Spring Sport ____________________________
Father’s/Guardian’s Name ____________________________ Bus. Phone _______ Cell or Pager _______
Mother’s/Guardian’s Name ____________________________ Bus. Phone _______ Cell or Pager _______
Emergency Contact ____________________________ Name & Relationship __________ Bus. Phone _______ Cell or Pager _______
Emergency Contact ____________________________ Name & Relationship __________ Bus. Phone _______ Cell or Pager _______
Emergency Contact ____________________________ Name & Relationship __________ Bus. Phone _______ Cell or Pager _______
Health and/or Insurance Carrier ____________________________ Policy # _______

The student and parent/guardian consent and authorize school officials through an Athletic Health Care Trainer (AHCT), qualified coach/staff, or physician as determined by the school, to provide any first aid and/or emergency care as well as follow-up first aid or medical treatment that may be reasonably necessary for the student as determined by a school official in the course of athletic practice, competition or travel.

The student and parent/guardian further consent and authorize the school’s AHCT to provide appropriate therapeutic modalities in order to return student to athletic competition, such care to be conducted under the direction of a physician.

The student and parent/guardian further consent and authorize the school’s AHCT to administer baseline and/or post injury concussion management assessment in order to manage a concussion or suspected head trauma, such care to be conducted under the direction of a physician.

The student and parent/guardian hereby consent to the release of medical information by physician to school to obtain information regarding the medical history, records of injury or surgery, serious illness, and rehabilitation results of the student from his/her physician(s). We understand that the purpose of this request for medical information is to assist the school in the management or rehabilitation of an injury/illness. This information is confidential and except as provided in this release will not be otherwise released by the parties in charge of the information. This release remains valid until revoked by the adult student or parent/guardian in writing.

Signature of Student ____________________________ Signature of Parent/Guardian ____________________________ Date _______

(Over)

To be completed by Physician only

Height _______ feet & inches _______ Weight _______ lbs _______ Blood Pressure _______ / _______ Pulse _______ bpm
Vision: R 20/400 L 20/400 _______ Corrected: Yes No Pupils: Equal _______ Unequal _______
Asthma _______ (Medication Used) _______ Diabetes _______ (Medication Used) _______ Allergies _______ (Medication Used)

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(Over)
Parent/Guardian and Student to fill out before Physical Examination

Explain "Yes" answers below. Circle question you don't know the answer to.

1. Has a doctor ever denied or restricted your participation in sports for any reason? Yes No
2. Do you have an ongoing medical condition (like diabetes or asthma)? Yes No
3. Are you currently taking any prescription or nonprescription (over the counter) medicines or pills? Yes No
4. Do you have allergies to medicines, pollens, foods, or stinging insects? Yes No
5. Have you ever passed out or nearly passed out DURING exercise? Yes No
6. Have you ever passed out or nearly passed out AFTER exercise? Yes No
7. Have you ever had discomfort, pain or pressure in your chest during exercise? Yes No
8. Does your heart race or skip beats during exercise? Yes No
9. Has a doctor ever told you that you have: (circle all that apply) High blood pressure A heart murmur
   High Cholesterol A heart infection
10. Has a doctor ever ordered a test for your heart? (for example, ECG, echocardiogram) Yes No
11. Has anyone in your family died for no apparent reason? Yes No
12. Does anyone in your family have a heart problem? Yes No
13. Has any family member or relative died of heart problems or of sudden death before age 50? Yes No
14. Has a family member died while exercising? Yes No
15. Does anyone in your family have Marfan Syndrome? Yes No
16. Have you ever spent the night in a hospital? Yes No
17. Have you ever had surgery? Yes No
18. Have you ever had an injury, like sprain, muscle or ligament tear, or tendonitis, that caused you to miss a practice or game? If yes, list affected area:

19. Have you had any broken or fractured bones or dislocated joints? If yes, list affected area:

20. Have you had a bone or joint injury that required x-rays, MRI, CT, surgery, injections, rehabilitation, physical therapy, a brace, cast, or crutches? If yes, list affected area:

21. Have you ever had a stress fracture? Yes No
22. Have you been told that you have or have you had an x-ray for atlantoaxial (neck) instability? Yes No
23. Do you regularly use a brace or assistive device? Yes No
24. Has a doctor ever told you that you have asthma or wheezing? Yes No

EXPLAIN "YES" answers here:
(Add additional pages if necessary)

I hereby verify to the best of my knowledge that the answers which have been provided to the above questions are correct.

Signature of Student __________________ Signature of Parent/Guardian __________________ Date __________

Clearance: (Place a check in appropriate box below)

☐ Cleared for all sports
☐ Cleared after completing evaluation/rehabilitation for
☐ Not cleared for: ☐ Collision (Football)
☐ Contact (Baseball, Basketball, Cheerleading, Judo, Softball, Soccer, Volleyball, Wrestling)
☐ Non contact ☐ Strenuous ☐ Moderately Strenuous ☐ Non-strenuous

Reason not cleared:

Physician’s Recommendation ______________ __________________ Date of Physical Exam __________
Name of Physician __________________ Telephone __________________
Address __________________ Fax Number __________________
Signature of Physician __________________