California Amateur Hockey Association
Concussion Awareness and Protocol
Coach Acknowledgement Form
Youth Hockey

Coach Name: ____

Level of Play: ________________________________ **Club:** ________________________________

1. **I understand that the California Amateur Hockey Association has adopted concussion-related education, awareness and protocol into their Guidebook and Rules of Play.**

2. **I understand the following guidelines and protocol exist, and will respect them if they must be instituted for any individual on the team:**
   a. **An athlete who is suspected of sustaining a concussion or head injury in an athletic activity shall be immediately removed from the activity for the remainder of the day. Removal from play can be at the request of a coach, official, team manager, parent/guardian, or the player.**
   b. **Athlete shall not be permitted to return to the activity until he/she is evaluated by a licensed health care provider, who is trained in the management of concussions, acting within the scope of his/her practice.**
   c. **Further, the athlete shall not be permitted to return to activity until he or she provides the approved and completed Concussion Release form, from that same licensed health care provider who is trained in the management of concussions, acting within the scope of his/her practice.**

3. **Should it be determined that a player needs to be removed from play, I understand that the protocol outlined herein shall be followed for the safety of the player.**

4. **I understand that if a suspected concussion has occurred and protocol has been enacted for a player, there is no review period or negotiation as to the course of action and return to play outside of the recommendations of the licensed healthcare provider, who is trained in the management of concussions, acting within the scope of his/her practice, that has been selected to treat the player.**

By the signature below, I acknowledge and agree to all of the information stated herein.

______________________________________ ____________________

Name **Date**

____

Signature

CAHA Concussion Clearance Form

This form must be completed and signed by a provider with a background in concussion management. This form is required before a player, if cleared, can return to play ice hockey. **Please initial any recommendations that you select below.** More information on concussions can be found at: http://cdc.gov/TraumaticBrainInjury/index.html

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Athlete's Name: ____

Date of Birth: ____

Date of Suspected Injury: ____

Cause of Suspected Injury: ____

THIS RETURN TO PLAY IS BASED ON TODAY'S EVALUATION

Date of Evaluation: ______________________ Care Plan Completed By: ______________________

Return to This Office (Date/Time): ____

RETURN TO SPORTS

PLEASE NOTE:

1. Athletes should not return to practice or play for at least 24 hours after their head injury has occurred.
2. Athletes should never return to play or practice if they still have ANY symptoms.
3. Athletes: Be sure that your coach and/or athletic trainer are aware of your injury and symptoms, and that they have the contact information for the treating physician.

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

Sports:

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

☐ May gradually return to sports practices and competition under the following conditions and with the following instructions: ____
____
____

☐ Must return to physician for final clearance to return to competition.

☐ Cleared for full participation in all activities and restrictions. Return of symptoms should result in re-evaluation by physician for assessment.

Medical Office Information (Please Print/Stamp):

Evaluator's Name: ____

Evaluator is an: _____MD _____DO Other ______________________________

Evaluator's Signature: ____

Evaluator's Address: ____

Office Phone: ________________________________

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Suggested Return to Play (RTP) Procedures After a Concussion

1. Return to activity and play is a medical decision. The athlete must meet all of the following criteria in order to progress to activity:

   Asymptomatic at rest and with exertion (including mental exertion in school) AND have written clearance from their primary care provider or concussion specialist (athlete must be cleared for progression to activity by a physician other than an Emergency Room physician, if diagnosed with a concussion).

2. Once the above criteria are met, the athlete will be progressed back to full activity following the step-wise process detailed below. (This progression must be closely supervised by a Certified Athletic Trainer. If your school does not have an athletic trainer, then the coach must have a very specific plan to follow as directed by the athlete's physician).

3. Progression is individualized, and will be determined on a case by case basis. Factors that may affect the rate of progression include: previous history of concussion, duration and type of symptoms, age of the athlete, and sport/activity in which the athlete participates. An athlete with a prior history of concussion, one who has had an extended duration of symptoms, or one who is participating in a collision or contact sport may progress more slowly. Further, concussion in females tends to take longer to heal and should be carefully watched.

4. Stepwise progression as described below:

   Step 1: Complete cognitive rest. This may include staying home from school or limiting school hours (and studying) for several days. Activities requiring concentration and attention may worsen symptoms and delay recovery.

   Step 2: Return to school full-time.

   Step 3: Light exercise. This step cannot begin until the athlete is no longer having concussion symptoms and is cleared by a physician for further activity. At this point the athlete may begin walking or riding an exercise bike. No weight-lifting or jumping/bouncing up and down.

   Step 4: Running in the gym or on the field. No helmet or other equipment.

   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. Must be cleared by physician before returning to play.

   - *The athlete should spend 1 to 2 days at each step before advancing to the next. If post-concussion symptoms occur at any step, the athlete must stop the activity and the treating physician must be contacted. Depending upon the specific type and severity of the symptoms, the athlete may be told to rest for 24 hours and then resume activity at a level one step below where he or she was at when the symptoms occurred.*

California Amateur Hockey Association
Concussion Awareness and Protocol
Parent/Guardian Acknowledgement Form
Youth Hockey

Player Name: ____

Level of Play: ______________________________ **Club:_____________________________________**

I am the: _____Parent _____ Legal Guardian _____ Adult-Aged Youth Athlete

1. **I understand that the California Amateur Hockey Association has adopted concussion-related education and awareness into their Guidebook and Rules of Play.**

2. **I understand the following guidelines exist and will respect them if they must be instituted with the above named player:**
   a. **An athlete who is suspected of sustaining a concussion or head injury in an athletic activity shall be immediately removed from the activity for the remainder of the day. Removal from play can be at the request of a coach, official, team manager, parent/guardian, or the player.**
   b. **Athlete shall not be permitted to return to the activity until he/she is evaluated by a licensed health care provider, who is trained in the management of concussions, acting within the scope of his/her practice.**
   c. **The athlete shall not be permitted to return to the activity until he or she receives written clearance to return to the activity from that licensed health care provider.**

3. **Should it be determined that the above named player needs to be removed from play, I/we understand that the protocol outlined herein shall be followed for the safety of the player. Further, I/we understand that the above named player will receive concussion education during the course of the season.**

4. **I understand that if a suspected concussion has occurred and protocol has been enacted for the above named player, there is no review period or negotiation as to the course of action and return to play outside of the recommendations of the licensed healthcare provider that I/we have selected to treat the above named player.**

5. **I understand that if I/we suspect the above named player has experienced a concussion or exhibits behavior that suggests concussion-like symptoms, I/we have the authority to remove the player from play and begin the concussion protocol with a licensed healthcare provider of my/our selection.**

By the signatures below, I/We acknowledge responsibility for the above named player in the current season, and agree to all of the information stated herein.

______________________________	______________________________
Name **Date**	**Name** **Date**