Sulphur Springs Independent School District
Concussion Safety Protocol

(Introduction

Sulphur Springs ISD is committed to protecting the health of and providing a safe environment for each of its participating UIL student-athletes. To this end, and in accordance with UIL legislation and new research supporting sport-related concussion care evaluation, Sulphur Springs High School and Middle School has adopted the following Concussion Safety Protocol for all UIL student-athletes. This protocol identifies expectations for institutional concussion management practices as they relate to (1) the definition of sport-related concussion; (2) independent medical care; (3) preseason education; (4) pre-participation assessment; (5) recognition and diagnosis; (6) initial suspected sport-related concussion evaluation; (7) post-concussion management; (8) return-to-learn management; (9) return-to-sport management; (10) reducing head impact exposure; and (11) written certificate of compliance signed by the district's athletic training staff.

1. **Definition of Sport-Related Concussion**

   The understanding of sport-related concussion continues to evolve. There is no uniform definition of sport-related concussion. What may appear to be only a mild jolt or blow to the head or body can result in a sport-related concussion or other serious brain injury. We now know that young athletes are particularly vulnerable to the effects of a sport-related concussion. An athlete does not need to lose consciousness (be "knocked-out") to suffer a sport-related concussion. In fact, less than 5% of concussed athletes suffer a loss of consciousness. The Consensus Statement on Concussion in Sport, which resulted from the 6th international conference on concussion in sport, defines sport-related concussion as follows:

   Sport-related concussion is a traumatic brain injury caused by a direct blow to the head, neck or body resulting in an impulsive force being transmitted to the brain that occurs in sports and exercise-related activities. This initiates a neurotransmitter and metabolic cascade, with possible axonal injury, blood flow change and inflammation affecting the brain. Symptoms and signs may present immediately, or evolve over minutes or hours, and commonly resolve within days, but may be prolonged. No abnormality is seen on standard structural neuroimaging studies (computed tomography or magnetic resonance imaging T1- and T2-weighted images), but in the research setting, abnormalities may be present on functional, blood flow or metabolic imaging studies. Sport-related concussion results in a range of clinical symptoms and signs that may or may not involve loss of consciousness. The clinical symptoms and signs of concussion cannot be explained solely by (but may occur concomitantly with) drug, alcohol, or medication use, other injuries (such as cervical injuries, peripheral vestibular dysfunction) or other comorbidities (such as psychological factors or coexisting medical conditions).

2. **Independent Medical Care**
   As required by UIL legislation, Christus Health System employed team physicians and athletic trainers shall have unchallengeable autonomous authority to determine medical management and return-to-activity decisions, including those pertaining to sport-related concussion and head trauma injuries, for all student-athletes.

3. **Preseason Education**
   All UIL student-athletes will be provided and allowed an opportunity to discuss sport-related concussion educational material (e.g., the UIL Concussion Acknowledgment Form) and will be required to sign the acknowledgement, on an annual basis and prior to participation, that they have been provided, reviewed and understood the concussion education material. This document will be uploaded to the Sulphur Springs Athletics website (sswildcats.com) for review at the discretion of the student athlete or stakeholders.

   All coaches, team physicians, athletic trainers, directors of athletics and other personnel involved in UIL student-athlete health and safety decision making will be formally educated and allowed an opportunity to discuss educational material, the UIL Concussion Acknowledgment Form and Concussion Safety Protocol and will be required to sign an acknowledgement, on an annual basis, that they have been provided, reviewed and understood the sport-related concussion education material.

4. **Pre-Participation Assessment**
   Any student who has been diagnosed with a sport-related concussion by a physician must get a new annual physical examination completed prior to being cleared to participate in a UIL practice or game for the upcoming school year. The physician will determine pre-participation clearance and/or the need for additional consultation or testing and or beyond for any UIL student-athlete with a documented sport-related concussion, especially those with complicated or multiple concussion history.

5. **Recognition and Diagnosis of Concussion**
   Medical personnel with training in the diagnosis, treatment and initial management of acute concussion must be present at all high school UIL competitions in the following contact/collision sports: (baseball; basketball; cheerleading; football; track/field including pole vault specifically; soccer; softball; volleyball). As well as at all middle school UIL competitions for football and soccer.

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NOTE: To be present means to be on site at the campus or arena of the competition. Medical personnel may be from either team or may be independently contracted for the event.

Medical personnel with training in the diagnosis, treatment and initial management of acute concussion must be available at all high school UIL practices in the following contact/collision sports: (baseball; basketball; cheerleading; football; track/field including pole vault specifically; soccer; softball; volleyball).

NOTE: To be available means that, at a minimum, medical personnel can be contacted at any time during the practice via telephone, messaging, email, beeper or other immediate communication means and that the case can be discussed through such communication, and immediate arrangements can be made for the athlete to be evaluated.

District medical personnel may not be present at all middle school UIL practices or competition in the following contact/collision sports: (basketball; cheerleading; football; track/field including pole vault specifically; soccer; volleyball). All athletics coaches employed at the middle school campus will be trained and educated on the use of the Concussion Recognition Tool (CRT6) if a sport-related concussion is suspected to determine if an athlete can continue to participate in practice/competition that day. Coaches are not permitted or trained to diagnose a sport-related concussion and will refer the athlete to be evaluated by district medical personnel at the earliest opportunity.

Any UIL student-athlete that exhibits signs, symptoms or behaviors consistent with concussion must be removed from practice or competition for evaluation. The signs that warrant immediate removal from the field include: actual or suspected loss of consciousness, seizure, tonic posturing, ataxia, poor balance, confusion, behavioral changes, and amnesia. Student-athletes exhibiting these signs or symptoms will not return to competition or practice that day unless evaluated by an experienced health care professional who determines that the sign was not related to a concussion.

Concussion evaluation:

A. Must be evaluated by an athletic trainer or team physician (or physician designee) with concussion experience.
B. On average it takes 10-15 minutes to complete a comprehensive exam when conducting a multi-modal screen (e.g., SCAT6) to evaluate a potential sport-related concussion. The evaluation must include the following component to be considered reliable in differentiating concussed athletes verses non-concussed athletes

a. Symptoms
b. Sign
c. Balance
d. Gait
e. Neurological and cognitive evaluation

C. The comprehensive sport-related concussion should be completed in a quiet area away from the competition or practice area.
D. Must be removed from practice/play for that calendar day if sport-related concussion is confirmed or suspected.
E. A student-athlete who was evaluated for the presence of sport-related concussion may only return to play the same day if the athletic trainer, team physician or physician designee determines that sport-related concussion is no longer suspected after the completion of the evaluation. Even in such cases, consider next day follow-up assessment because initial symptoms may not appear for several hours.

Failure to remove the athlete from activity puts them at risk for sustaining another head injury while concussed, which can lead to worsening concussion symptoms, increased risk for further injury, and, sometimes even death. Parents/guardians and coaches are not allowed or trained to “diagnose” a concussion. However, everyone involved in athletics must be aware of the signs, symptoms and behaviors associated with a concussion.

6. **Initial Suspected Concussion Evaluation**
   The initial concussion evaluation must be performed by a medical professional and must include an immediate assessment/neurological screen for “red flags” or observable signs (as noted in the Concussion Emergency Action Plan below). The assessment may include a multi-modal evaluation as clinically indicated such as:
   A. Clinical assessment to rule out cervical spine trauma, skull fracture, intracranial bleed or other catastrophic injury.
   B. Symptom assessment *(Sport Concussion Assessment Tool 6 (SCAT6): Step 2 Symptom Evaluation)*
   C. Physical *(Cervical range of motion, Cervical distraction test, and)*
   D. Neurological exam. *(Cranial Nerve screening, Spurling Test, and Visual Ocular Motor Screen)*
   E. Cognitive assessment. *(SCAT6: Step 3 Cognitive Screening and Step 5 Delayed Recall)*
   F. Balance exam. *(SCAT6: Step 4 Coordination and Balance Examination)*

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Concussion Emergency Action Plans

If any of the following signs, symptoms, or behaviors are present in any competition or practice the student-athlete must be immediately removed from play and assessed for possible transport to an emergency facility or trauma center.

- Neck pain or tenderness.
- Seizure or convulsion.
- Double vision.
- Loss of consciousness.
- Weakness or tingling/burning in more than one arm or in the legs.
- Deteriorating conscious state.
- Vomiting.
- Severe or increasing headache.
- Increasingly restless, agitated or combative.
- Glasgow Coma Scale Score <15
- Visible deformity of the skull.

Most concussions do not involve a structural injury to the brain, but if any of the above symptoms are observed and if after examination any of the following conditions listed below are suspected in the differential diagnosis the student will immediately be transported to an emergency facility or trauma center, as these conditions require a higher level of care.

A. C-spine fracture
    a. C-spine tenderness
    b. Decreased or painful C-spine range of motion
    c. Loss of bladder/bowel control
B. Skull fracture
    a. Obvious scalp / skull deformity
    b. Ecchymosis (bruising) around the eyes or behind the ears
    c. Spinal fluid (CSF) leakage from ears or nose
C. Hematoma (intra-cranial bleeding)
    a. If unrecognized, initial "concussion" may progress to coma and death due to expanding mass within the skull
        i. Epidural – from the middle meningeal artery (arterial source) usually associated with skull fracture
        ii. Subdural – from direct brain injury or venous shear (venous source)
D. Second Impact Syndrome
    a. Repeat head injury sustained prior to full recovery from previous head injury, associated with massive brain swelling; carries up to 50 % mortality rate

7. **Post-concussion Management**
   For all diagnosed sport-related concussions, there must be documented evidence that the post-concussion plan of care was communicated to both the student-athlete and their parent or guardian. This communication may be provided orally and/or in written form. Because symptoms of a concussion may develop or change over time, a process for serial evaluation of the student-athlete must be in place. This follow-up evaluation must occur within 72 hours of the initial diagnosis to ensure appropriate monitoring and necessary adjustments to the plan of care. The SCAT6 will only be utilized in the first 72 hours of injury. Post 72 hours of injury the Sport Concussion Office Assessment Tool 6 (SCOAT6) will be utilized to evaluate the presence of a sport-related concussion. It may be helpful in providing a standardized framework from which a clinical, office-based evaluation can be conducted to evaluate the following that are not accounted for on the SCAT6.
   - Screen for fear, anxiety or depression or other mental health issues
   - Screen for sleep disturbance.
   - Graded aerobic exercise testing.
   - Modified VOMS

   For all concussion management plans:

- The first stage in recovering from a sport-related concussion is relative rest. Athletes with a sport-related concussion need rest from physical and mental activities that require concentration and attention as these activities may worsen symptoms and delay recovery. Exposure to loud noises, bright lights, computers, video games, television and phones all may worsen the symptoms of a sport-related concussion. Athletes typically require 24-48 hours of relative rest, which include activities of daily living and reduced screen time.
- The second stage in recovery introduces light-aerobic activity. “Strong evidence exists regarding the benefits of physical activity and aerobic exercise treatment as early interventions.” Individuals can return to light-intensity aerobic activity, such as walking that does not more than mildly exacerbate symptoms, during the initial 24-48 hours following a sport-related concussion.
- The third stage may occur concurrently with with stage two with the gradual progression of return-to-learn activity as outlined in subsection 8 titled Return-to-Learn (RTL) Management
- The fourth stage may occur concurrently with with stage three with the gradual progression of return-to-sport activity as outlined in subsection 9 titled Return-to-Sport (RTS) Management
- From initial injury to unrestricted RTS recovery from a sport-related concussion takes approximately 10 days to 1 month.

Re-Evaluation:

Any UIL student-athlete with atypical presentation or persisting symptoms (concussion symptoms lasting longer than 4 weeks) will be referred to a physician in order to consider additional diagnoses, best management options, and consideration of referral. Additional diagnoses include but are not limited to: fatigue and/or sleep disorder; migraine or other headache disorders; mental health symptoms and disorders; ocular dysfunction; cervical and vestibular dysfunction; cognitive impairment and autonomic dysfunction including orthostatic intolerance and postural orthostatic tachycardia syndrome; pain.

8. **Return-to-Learn Management** (Please disregard will meet with curriculum director on August 6th to finalize create district policy)

The vast majority of young adults have a full return-to-learn with no additional academic support by 10 days post-injury. Complete rest and isolation should be avoided, even during the initial 24-48 hours post-injury. Relative rest is important in the first 24 hours. For those student-athletes with persisting symptoms a more formal plan may be in order.

The return-to-learn concept should follow an individualized and step-wise process overseen by a point person within the athletics department, who will navigate return-to-learn with the student-athlete and, in more complex cases of prolonged return-to-learn, work in conjunction with a multi-disciplinary team that may vary student-to-student depending on the specifics of the case but may include, but is not limited to:

(List all that apply.)

- Team physician.
- Athletic trainer.
- Psychologist/counselor. (Identify if student health services or department of athletics)
- Neuropsychologist.
- Medical specialists.
- Faculty athletics representative.
- Academic counselor.
- Course instructor(s).
- College administrators.
- Office of disability services representative.
- Coaches.

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A student-athlete who has suffered a concussion will return to classroom/studying as tolerated with modification of schedule/academic accommodations, as indicated, with help from the identified point-person. The plan may address environment, physical, curriculum and/or testing adjustments. Campus resources will be engaged for cases that cannot be managed through schedule modification/academic accommodations. Campus resources will be consistent with the ADAAA and will include one of the following:

- Learning specialists.
- Office of disability services.
- ADAAA office.

A student-athlete will be re-evaluated by a team physician (or their designee) and members of the multi-disciplinary team, as appropriate, if concussion symptoms worsen with academic challenges or in the event of atypical presentation or persisting symptoms.

9. **Return-to-Sport Management**

Unrestricted return-to-sport should not occur prior to unrestricted return-to-learn for sport-related concussions diagnosed while the student-athlete is enrolled in classes. Strict rest and isolation should be avoided as research indicates it may delay/prolong healing, even during the initial 24-48 hours. Relative rest is recommended as opposed to strict rest in the first 24 hours. Final determination of unrestricted return-to-sport will be made by the student-athlete's Primary care physician (PCP) or their medically qualified designee following implementation of an individualized, supervised stepwise progression management plan. The below stepwise progression must be supervised by a health care provider with expertise in concussion. Progression to the next step in the sequence must be at least 24 hours after full completion of the previous step.

	Timeline	Exercise	Goal
Step 1	After 24-48 hours post-injury	- Symptom-limited activities of daily living. - Stationary bike for 10 minutes with no resistance	Gradual reintroduction of work/school
Step 2A	Step 2A and 2B must be done at least 8 hours apart	Light aerobic exercise (up to 55% of max heart) Treadmill walk with no incline for 15 minutes; speed 2.5-3.2 **OR** stationary bike with level 5 resistance for 15 minutes Accessory exercises from Step 1 of Carolina Sports Concussion Clinic:	Increase heart rate

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		Concussion Protocol Exercise Progression	
Step 2B		- Moderate aerobic exercise (up to 70% of max heart) - Treadmill walk with 10 incline for at speed 2.5-3.2 for 25 minutes; **OR** stationary bike with level 10 resistance for 25 minutes; **OR** treadmill jog with no incline at speed 4-5.5 for 20 minutes - - Accessory exercises from step 2 of Carolina Sports Concussion Clinic: Concussion Protocol Exercise Progression	Progress increasing heart rate
Step 3	After evaluated and written clearance given by PCP and at least 24 hours after previous step is completed and student is asymptomatic	Individual sport-specific exercise Warmup Treadmill run for 10 minutes at speed ≥ 4.5 Sport-specific drills from step 3 of Carolina Sports Concussion Clinic: Concussion Protocol Exercise Progression Cool down Treadmill run for 10 minutes at speed ≥ 4.5	Add movement, change of direction
Step 4	24 hours after previous step is completed and student is asymptomatic	Non-contact practice	Resume usual intensity of exercise, coordination and increased thinking
Step 5	24 hours after previous step is completed and student is asymptomatic	Full contact practice	Restore confidence and assess functional skills by coaching staff
Step 6	24 hours after previous step is completed and student is asymptomatic	Unrestricted return to play	

NOTE: Mild and brief exacerbation of symptoms (ie, an increase of no more than 2 points on a 0–10 point scale for less than an hour when compared with the baseline value reported prior to physical activity). Athletes may begin Step 1 (ie, symptom-limited activity) within 24 hours of injury, with progression through each subsequent step typically taking a minimum of 24 hours. If more than mild exacerbation of symptoms (ie, more than 2 points on a 0–10 scale) occurs during Steps 1–2B, the athlete should stop and attempt to exercise the next day. Athletes experiencing concussion-related symptoms during Steps 3–5 should return to Step 2B to establish full

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resolution of symptoms with exertion before engaging in at-risk activities. Written determination of readiness to RTS should be provided by an HCP before unrestricted RTS as directed by local laws and/or sporting regulations.

10. Reducing Head Impact Exposure

Sulphur Spring ISD is committed to protecting the health of and providing a safe environment for each of its participating UIL student-athletes. To this end and in accordance with UIL and NCAA association-wide policy, Sulphur Springs ISD will reduce student-athlete head impact exposure in a manner consistent with Interassociation Recommendations: Preventing Catastrophic Injury and Death in Collegiate Athletes and Consensus statement on concussion in sport: the 6th International Conference on Concussion in Sport. For example:

- Sulphur Springs High School and Middle School teams will adhere to existing ethical standards in all practices and competitions.
- Using playing or protective equipment (including the helmet) as a weapon will be prohibited during all practices and competitions.
- Deliberately inflicting injury on another player will be prohibited in all practices and competitions.
- All playing and protective equipment (including helmets), as applicable, will meet relevant equipment safety standards and related certification requirements.
- Sulphur Springs High School and Middle School will keep the head out of blocking and tackling in contact/collision, helmeted practices and competitions.
- Sulphur Springs High School and Middle School will emphasize education of proper technique to reduce head impact exposure for all contact and collision sports, with special emphasis in pre-season.
- Sulphur Springs High School and Middle School will adhere to policies and rules in sport that limit the number and duration of contact practices and activities in contact-collision sports.
- Consideration of participation in neuromuscular training warm-up programs.
- It is recommended that all players wear a mouthguard.

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Compliance Certification*
Implemented Academic Year 2026-27

Concussion Management Plan
By signing and dating this form, I hereby acknowledge, on behalf of the institution identified above, that beginning in the **2026-27** academic year, the attached Sulphur Springs ISD Concussion Safety Protocol is consistent with the UIL Concussion Safety Protocol Checklist and otherwise fulfills the requirements of all applicable UIL Concussion Management Plan legislation. This form is subjected to revision as needed to align with any changes implemented by the district, UIL, or overall consensus to reflect best practices in concussion care, which it will be updated, reviewed, and resigned.

Athletic Trainer
Print Name: ________________________________
Sign: _____________________________________
Date: ________________________________

Athletic Trainer
Print Name:__________________________
Sign: ________________________________
Date: ________________________________

Athletic Trainer
Print Name: ________________________________
Sign: _____________________________________
Date: ________________________________

Athletic Director
Print Name:__________________________
Sign: ________________________________
Date: ________________________________

Christus Sports Medicine Coordinator
Print Name: ________________________________
Sign: _____________________________________
Date: ________________________________

Christus Team Physician
Print Name:__________________________
Sign: ________________________________
Date: ________________________________

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References

https://bjsm.bmj.com/content/bjsports/57/11/695.full.pdf

https://assets.nfhs.org/umbraco/media/7212694/suggested-guidelines-for-management-of-concussion-in-sports-nfhs-smac-final-october-2023.pdf

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