****

**Marymount University Concussion Policy Summary**

**Table of Contents**

**1** Purpose, Organization and Responsibilities

**II** Policy and Acknowledgement Waivers

Student-Athlete

 MU Athletic or Spirit Employee

 MU Contract Worker or Volunteer

**III** APPENDIX – NCAA Concussion Policy

**IV** APPENDIX – Department Concussion Policies

 Athletic Training (AT)

 Shared Policy between SHC and AT

 Student Health Center (SHC)

 Spirit Programs

 Student Access Services (SAS)

**III** APPENDIX – NCAA Fact Sheet Handout

**I - Purpose:**

In accordance with the NCAA Concussion Policy and Legislation, this document summarizes the individual Marymount University departmental policies regarding handling of concussions and to ensure consistent and appropriate procedures.

*“The NCAA Concussion Policy and Legislation mandates that institutions implement the following:1) An annual process that ensures student-athletes are educated about the signs and symptoms of concussion; 2) A process that ensures a student-athlete who exhibits signs, symptoms or behaviors consistent with a concussion shall be removed from athletics activities and evaluated by a medical staff member with experience in the evaluation and management of concussion; 3) A policy that precludes a student-athlete diagnosed with a concussion from returning to athletic activity for at least the remainder of that calendar day; and 4) a policy that requires medical clearance for a student-athlete diagnosed with a concussion to return to athletics activity as determined by a physician or the physician’s designee.”*

This document also provides for the educational material and acknowledgement waivers to confirm the education and understanding about concussions by student-athletes, employee and contract workers and volunteers in accordance with the NCAA Concussion Policy Guidelines.

“*Education: Institutions should provide applicable NCAA concussion fact sheets or other applicable educational material annually to student-athletes, coaches, team physicians, athletic trainers, and athletics directors. There should be a signed acknowledgement that all parties have read and understand these concussion facts and their institution’s concussion management plan.”*

**I - Organization and Responsibilities**

**Marymount University** departments involved in potential student-athlete concussion issues are:

* 1. **Athletics –** coaches
	2. **Athletic Training –** certified athletic trainers and supervising physicians
	3. **Spirit Program –** cheer and dance coaches
	4. **Student Health Center –** nurses and consulting physicians
	5. **Student Access Services –** disability support services
	6. **Risk Management –** concussion training courses

Although each of these departments may have their own individual policy and protocol, they all follow the same **Concussion Management Plan** guidelines to ensure the safety of student-athletes with the following criteria:

* **Education:**
	+ Educate student-athletes, coaches, staff and contract workers (Free on-line concussion training available through Risk Management)
	+ Documentation of concussion signs and symptoms (NCAA concussion fact sheets)
	+ Completion of a waiver acknowledgement (See part I above)
* **Pre-participation assessment:**
	+ A one-time, pre-participation baseline concussion assessment
	+ Medical history
	+ Confirmation of health and accident insurance coverage.
* **Incident protocol:**
	+ Recognition and diagnosis of concussion
	+ Post-concussion management including clinical evaluation at the time of injury by ATCs or MD on sideline, assessment for head and cervical spine injury at time of injury and implementation of the emergency action plan, as warranted; serial evaluation and monitoring for deterioration following injury. Notify team physician of any patient with symptoms concerning for fracture or intra-cranial bleed or more severe injury and send immediately to the nearest emergency department.
	+ All athletes with a diagnosed concussion will have 48 hours rest from school and sports and have a stepwise recuperation for return to activity; return to play and return to academics.

**II - Policy and Acknowledgement Waiver – Student Athlete**

Marymount University has a responsibility to educate its student-athletes of the signs and symptoms of mild traumatic brain injuries, otherwise known as concussions. The MU Athletic Training and Spirit Program Staff are trained to recognize those that may present with concussive-type symptoms. However, many concussions can go unreported. It is imperative that those student-athletes who suspect they may be suffering from a concussion, report it to their Athletic Trainer or Spirit Staff or Student Health Center. Below is a definition of a concussion and common signs and symptoms:

Definition of Concussion:

A concussion is the most common type of brain injury. It is the result of a direct blow to the head or body causing the head and brain to move quickly back and forth. Concussion is diagnosed based on the appropriate history with a constellation of signs and symptoms, many of these signs and symptoms listed below. It is important to understand that the signs and symptoms listed below are common for a concussion, but not all of the symptoms need to exist for a person to be diagnosed with a concussion:

Headache

Neck pain

Nausea

Loss of appetite

Balance problems/Dizziness

Drowsiness/Fatigue

Difficulty sleeping

Nervousness/Anxiety

Sensitivity to light/noise

Continued double vision

Altered emotions

Ringing in the ears

Feeling slowed down

Feeling in a ‘fog’

Difficulty concentrating or remembering

Confusion/Disorientation

Blurred vision

Changes in mood

**STUDENT-ATHLETE WAIVER:**

By signing below, I acknowledge that I have read and understood the information regarding concussions that apply to my particular sport or activity. I acknowledge that I have received the NCAA fact sheet regarding concussions. I know and understand that I should notify the head of my athletic team or activity when I suspect I may have sustained a concussion. I take full responsibility for notifying the head of my athletic or activity if I think I may have a concussion, and I also take full responsibility for any injuries or other problems that might occur to me or others as a result of a concussion.

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

Signature of Student-Athlete Date

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

Printed Name of Student-Athlete

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

Signature of Parent/Guardian Date

(If student-athletes is under 18 years of age)

**II - Policy and Acknowledgement Waiver – MU Employees**

Marymount University has a responsibility to educate its student-athletes of the signs and symptoms of mild traumatic brain injuries, otherwise known as concussions. The MU Athletic Training and Spirit Program Staff are trained to recognize those that may present with concussive-type symptoms. However, many concussions can go unreported. It is imperative that those student-athletes who suspect they may be suffering from a concussion, report it to their Athletic Trainer or Spirit Staff or Student Health Center. Below is a definition of a concussion and common signs and symptoms:

Definition of Concussion:

A concussion is the most common type of brain injury. It is the result of a direct blow to the head or body causing the head and brain to move quickly back and forth. Concussion is diagnosed based on the appropriate history with a constellation of signs and symptoms, many of these signs and symptoms listed below. It is important to understand that the signs and symptoms listed below are common for a concussion, but not all of the symptoms need to exist for a person to be diagnosed with a concussion:

Headache

Neck pain

Nausea

Loss of appetite

Balance problems/Dizziness

Drowsiness/Fatigue

Difficulty sleeping

Nervousness/Anxiety

Sensitivity to light/noise

Continued double vision

Altered emotions

Ringing in the ears

Feeling slowed down

Feeling in a ‘fog’

Difficulty concentrating or remembering

Confusion/Disorientation

Blurred vision

Changes in mood

**MU EMPLOYEE WAIVER:**

By signing below, I acknowledge that I have read and understood the information regarding concussions that apply to my department and my particular sport or activity. I acknowledge that I have received the NCAA fact sheet regarding concussions. I will immediately communicate a student-athlete notification of a potential concussion to the head of my department or university physician, or designee.

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

Signature of MU Employee Date

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

Printed Name of MU Employee

**II - Policy and Acknowledgement Waiver – MU Contract Worker/Volunteer**

Marymount University has a responsibility to educate its student-athletes of the signs and symptoms of mild traumatic brain injuries, otherwise known as concussions. The MU Athletic Training and Spirit Program Staff are trained to recognize those that may present with concussive-type symptoms. However, many concussions can go unreported. It is imperative that those student-athletes who suspect they may be suffering from a concussion, report it to their Athletic Trainer or Spirit Staff or Student Health Center. Below is a definition of a concussion and common signs and symptoms:

Definition of Concussion:

A concussion is the most common type of brain injury. It is the result of a direct blow to the head or body causing the head and brain to move quickly back and forth. Concussion is diagnosed based on the appropriate history with a constellation of signs and symptoms, many of these signs and symptoms listed below. It is important to understand that the signs and symptoms listed below are common for a concussion, but not all of the symptoms need to exist for a person to be diagnosed with a concussion:

Headache

Neck pain

Nausea

Loss of appetite

Balance problems/Dizziness

Drowsiness/Fatigue

Difficulty sleeping

Nervousness/Anxiety

Sensitivity to light/noise

Continued double vision

Altered emotions

Ringing in the ears

Feeling slowed down

Feeling in a ‘fog’

Difficulty concentrating or remembering

Confusion/Disorientation

Blurred vision

Changes in mood

**MU CONTRACT WORKER/VOLUNTEER WAIVER:**

By signing below, I acknowledge that I have read and understood the information regarding concussions that apply to my department and my particular sport or activity. I acknowledge that I have received the NCAA fact sheet regarding concussions. I will immediately communicate a student-athlete notification of a potential concussion to the head of my department or university physician, or designee.

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

Signature of MU Contract Worker/Volunteer Date

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

Printed Name of MU Contract Worker/Volunteer

**III - APPENDIX – NCAA Concussion Guidelines (4.15) http://www.ncaa.org/health-and-safety/concussion-guidelines**

**Concussion guidelines -**Diagnosis and Management of Sport-Related Concussion Guidelines

**Purpose:**

The *Safety in College Football Summit* (see [appendix](http://www.ncaa.org/health-and-safety/appendix)) resulted in inter-association consensus guidelines for three paramount safety issues in collegiate athletics:

1. Independent medical care in the collegiate setting;
2. Concussion diagnosis and management; and
3. Football practice contact.

This document addresses diagnosis and management of sport-related concussion in the collegiate setting for *all* sports.

**Background:**

There are more than 42 consensus-based definitions of concussion. A recently published, evidence-based definition of concussion follows.1

Concussion is:

* a change in brain function,
* following a force to the head, which
* may be accompanied by temporary loss of consciousness, but is
* identified in awake individuals, with
* measures of neurologic and cognitive dysfunction.

Diagnosis and management of sport-related concussion is a clinical diagnosis based on the judgment of the student-athlete’s health care providers.2 The diagnosis and management of sport-related concussion is challenging for many reasons:

* The physical and cognitive examinations are often normal, and additional tests such as brain computerized tomography (CT), brain MRI, electroencephalogram and blood tests are also commonly normal. Although comprehensive neuropsychological tests may be a useful adjunctive tool supporting the diagnosis of sport-related concussion, there remains controversy regarding interpretation and utility as a clinical tool.
* The clinical effects of sport-related concussion are often subtle and difficult to detect with existing sport-related concussion assessment tools.
* The symptoms of sport-related concussion are not specific to concussion and it is challenging to evaluate a student-athlete who presents non-specific symptoms that may be related to other conditions.
* Sport-related concussion may manifest with immediate or delayed-onset symptoms. Symptom manifestation can vary between individuals and in the same individual who has suffered a repeat concussion.
* Modifying factors and co-morbidities­ -- such as attention deficit hyperactivity disorder, migraine and other headache disorders, learning disabilities and mood disorders -- should be considered in making the diagnosis, in providing a management plan, and in making both return-to-play and return-to-learn recommendations.3-7
* “Signal detection” on clinical measures (e.g., cognitive and balance testing) often quickly diminishes in the acute setting of early recovery. Although cognitive function and balance assessed within 24 hours with various sideline tests (Standardized Assessment of Concussion [SAC] and Balance Error Scoring System, respectively) have been shown to be useful in diagnosing concussion, these tests often normalize within a few days and cannot be used to make a definitive diagnosis.
* Student-athletes may underreport symptoms and inflate their level of recovery in hopes of being rapidly cleared for return to competition.8,9
* Clinical assessment of sport-related concussion is a surrogate index of recovery and not a direct measure of brain structure and functional integrity after concussion.

In summary, the natural history of concussion remains poorly defined, diagnosis can be difficult, there are often few objective findings for diagnosis or physiological recovery that exist for clinical use, and there often remains a significant reliance on self-report of symptoms from the student-athlete.

The *NCAA Concussion Policy and Legislation* mandates that institutions implement the following:10

An annual process that ensures student-athletes are educated about the signs and symptoms of concussion;

A process that ensures a student-athlete who exhibits signs, symptoms or behaviors consistent with a concussion shall be removed from athletics activities and evaluated by a medical staff member with experience in the evaluation and management of concussion;

A policy that precludes a student-athlete diagnosed with a concussion from returning to athletic activity for at least the remainder of that calendar day; and

A policy that **requires medical clearance** for a student-athlete diagnosed with a concussion to return to athletics activity as determined by a physician or the physician’s designee.

**Guidelines:**

The goals of developing guidelines for the diagnosis and management of sport-related concussion are: (1) helping athletic health care providers to diagnose and manage sport-related concussion; (2) developing prevention strategies for sport-related concussions and repeat sport-related concussion; (3) promoting sport-related concussion injury resolution; (4) minimizing factors that contribute to prolonged or recurrent symptoms of sport-related concussion; and (5) preventing or minimizing complications of other co-morbidities that may accompany sport-related concussion (e.g., ADHD, migraine and other headache disorders, learning disabilities and mood disorders).

**Concussion Management Plan:**

Institutions should make their concussion management plan publically available, either through printed material, their website, or both. Guideline components of a concussion management plan are:

1. **Education:** Institutions should provide applicable NCAA concussion fact sheets or other applicable educational material annually to student-athletes, coaches, team physicians, athletic trainers, and athletics directors.  There should be a signed acknowledgement that all parties have read and understand these concussion facts and their institution’s concussion management plan.
2. **Pre-participation assessment**: A one-time, pre-participation baseline concussion assessment for all varsity student-athletes should include, but not necessarily be limited to:
	* A brain injury/concussion history;
	* Symptom evaluation;
	* Cognitive assessment; and
	* Balance evaluation.

The team physician should determine pre-participation clearance and/or the need for additional consultation or testing.11

1. **Recognition and diagnosis of concussion**: All student-athletes who are experiencing signs, symptoms or behaviors consistent with a sport-related concussion, at rest or with exertion, must be removed from practice or competition and referred to an athletic trainer or team physician with experience in concussion management.  A student-athlete’s health care provider experienced in the diagnosis and management of concussion should conduct and document serial clinical evaluation inclusive of symptom inventory and evaluation of cognition and balance. A student-athlete diagnosed with sport-related concussion should not be allowed to return to play in the current game or practice and should be withheld from athletic activity for the remainder of the day. Disposition decisions for more serious injuries such as cervical spine trauma, skull fracture or intracranial bleed, should be made at the time of presentation.
2. **Post-concussion management:** The foundation of sport-related concussion management is initial physical and relative cognitive rest as part of an individualized treatment plan.2. Initial management of sport-related concussion is based on individual serial clinical assessments, taking a concussion history, modifying factors, and taking specific needs of the student-athlete into consideration. Such management includes, but is not limited to:
	* Clinical evaluation at the time of injury. When the rapid assessment of concussion is necessary (e.g., during competition), symptom assessment, physical and neurological exam, and balance exam should be performed.  Brief concussion-evaluation tools such as the Standardized Concussion Assessment Tool 3 (SCAT3), which includes the Standardized Assessment of Concussion (SAC), provide standardized methods and can be compared to a baseline evaluation.12
	* Assessment for head and cervical spine injury at time of injury and implementation of the emergency action plan, as warranted.
	* Transportation to the nearest hospital if any of following signs and symptoms are present: Glasgow Coma score less than 13; prolonged period of loss of consciousness (longer than 1 minute); focal neurological deficit; emesis; persistently diminished or worsening mental status or other neurological signs or symptoms; or potential spine injury or any symptoms concerning to the provider and need for further evaluation.
	* Serial evaluation and monitoring for deterioration following injury. Upon discharge from medical care, both oral and written instructions for home care should be given to the student-athlete and to a responsible adult (e.g., parent or roommate) who should continue to monitor and supervise the student-athlete during the acute phase of sport-related concussion.12

**Return to activity:**

Sport-related concussion is a challenging injury for student-athletes and, unlike other injuries, the timeline for return to full activity (including return-to-play and return-to-learn) is often difficult to project. The psychological response to injury is also unpredictable. Sometimes, student-athletes who are kept out of their sport for a prolonged period of time experience emotional distress related to being unable to participate in sport. 13 It is important that health care providers remain alert to the signs and symptoms of depression and other emotional responses to injury that can be particularly challenging following concussive injury.13  A student-athlete’s health care providers should verify the diagnosis instead of assuming that the student-athlete has prolonged concussion symptoms. These symptoms may represent post-concussion syndrome, sleep dysfunction, migraine or other headache disorders, or co-morbid mood disorders such as anxiety and depression.7 Passive management, such as prolonged physical and cognitive rest, may be counter-productive in these scenarios.

**Return-to-Play:**

Once a student-athlete has returned to his/her baseline, the return-to-play decision is based on a protocol of a stepwise increase in physical activity that includes both an incremental increase in physical demands and contact risk supervised by a physician or physician-designee.12  Most return-to-play protocols are similar to those in the *Consensus Statement on Concussion in Sport* guidelines,2 which outline a progressive increase in physical activity if the individual is at baseline before starting the protocol and remains at baseline throughout each step of the protocol. It is noteworthy that all return-to-play guidelines are consensus-based and have not been validated by evidence-based studies.14-15  McCrea and colleagues16 have reported that a symptom-free waiting period is not predictive of either clinical recovery or risk of a repeat concussion. Further, student-athletes have variable understanding of the importance of reporting possible concussion symptoms.8-9  In summary, it should be recognized that current return-to-play guidelines are based on expert consensus.

There is emerging evidence that focused exercise or recovery techniques may be utilized before full recovery has occurred, but more study is needed. Given the paucity of scientific evidence regarding return-to-play and expert consensus documents that have been published, adherence to consensus guidelines is recommended. However, it is important to stress an individualized approach for return-to-play. Some student-athletes may have minimal concussive symptomatology with minimal symptom duration and no modifiers (conditions that may prolong recovery such as prior concussion, migraine, ADHD, depression/anxiety). In scenarios of this nature, and with experienced clinicians in a highly select setting, the return-to-play protocol may be modified.17  In contrast, if a student-athlete has a concussion history, increased symptom burden or duration, or has symptoms for three to four weeks with other concussion modifiers, then the return-to-play progression should proceed more cautiously and each stage may take more than a day.12

Distinctive neurological deficits, such as vestibular or oculo-motor dysfunction, should be specifically addressed to avoid prolonged return-to-play. For example, if a student-athlete suffers from vestibular dysfunction as a manifestation of sport-related concussion, and is unable to progress in the return-to-play protocol, it is important to address the specific vestibular dysfunction rather than to simply return the student-athlete to the previous level of return-to-play progression.7  In other words, ‘rest’ can sometimes lead to adverse outcomes if an accurate diagnosis based on neurological dysfunction is not made. The guidelines presented herein serve as a general guide and are not meant to be prescriptive.

**Stepwise progression:**

The initial management of sport-related concussion is relative physical and cognitive rest. Athletes diagnosed with sport-related concussion must be removed from play and must not return to sport-related activity for at least one calendar day and are to be evaluated by a health care provider with expertise in sport-related concussion. Once a concussed student-athlete has returned to baseline level of symptoms, cognitive function and balance, then the return-to-play progression can be initiated, as follows in this general outline:

1. Light aerobic exercise such as walking, swimming or riding a stationary bike. No resistance training. If asymptomatic with light aerobic exercise, then;
2. Mode, duration and intensity-dependent exercise based upon sport. If asymptomatic with such exertion, then;
3. Sport-specific activity with no head impact. If asymptomatic with sport-specific activity, then;
4. Non-contact sport drills and resumption of progressive resistance training. If asymptomatic with non-contact drills and resistance training, then;
5. Full-contact practice. If asymptomatic with full-contact practice, then;
6. Return-to-play. Medical clearance will be determined by the team physician/physician designee, or athletic trainer in consultation with a team physician.

At any point, if the student-athlete becomes symptomatic (i.e., more symptomatic than baseline), or scores on clinical/cognitive measures decline, the team physician should be notified and the student-athlete should be returned to the previous level of activity after 24 hours of rest. Final determination of return-to-play ultimately resides with the team physician/physician designee.

**Return to academics:**

Return to academics (return-to-learn) is a parallel concept to return-to-play,6,18-20 but has received less scientific evaluation.  Return-to-learn guidelines assume that both physical and cognitive activities require brain energy utilization, and that after a sport-related concussion, brain energy may not be available for physical and cognitive exertion because of a brain energy crisis.3 Return-to-learn should be managed in a stepwise program that fits the needs of the individual, within the context of a multi-disciplinary team that includes physicians, athletic trainers, coaches, psychologists/counselors, neuropsychologists, administrators as well as academic (e.g. professors, deans, academic advisors) and office of disability services representatives.  The return-to-learn recommendations outlined below are based on expert consensus.  Like return-to-play, it is difficult to provide prescriptive recommendations for return-to-learn.  The student-athlete may appear physically normal but may be unable to perform as expected due to concussive symptomatology.

**Stepwise progression:**

As with return-to-play, the first step of return-to-learn is relative physical and cognitive rest.  Relative cognitive rest involves minimizing potential cognitive stressors, such as school work, video games, reading, texting and watching television.  Data from small studies suggest a beneficial effect of cognitive rest on concussion recovery.20  For the college student-athlete, consideration should be given to avoiding the classroom for at least the same day as the sport-related concussion.  The period of time needed to avoid class or homework should be individualized.  The gradual return to academics should be based on the absence of concussion symptoms following cognitive exposure.  The consensus to date includes:3,19

1. If the student-athlete cannot tolerate light cognitive activity, he or she should remain at home or in the residence hall.
2. Once the student-athlete can tolerate cognitive activity without return of symptoms, he/she should return to the classroom, often in graduated increments.

At any point, if the student-athlete becomes symptomatic (i.e., more symptomatic than baseline), or scores on clinical/cognitive measures decline, the team physician should be notified and the student-athlete’s cognitive activity reassessed.

The extent of academic adjustments needed should be decided by a multi-disciplinary team that may include the team physician, athletic trainer, faculty athletics representative or other faculty representative, coach, individual teachers, neuropsychologist and psychologist/counselor.  The level of multi-disciplinary involvement will vary on a case-by-case basis.  The majority of student-athletes who are concussed will not need a detailed return-to-learn program because full recovery typically occurs within two weeks.  For the student-athlete whose academic schedule requires some minor modification in the first one to two weeks following a sport-related concussion, adjustments can often be made without requiring meaningful curriculum or testing alterations.

For those student-athletes whose symptoms persist for longer than two weeks, there are differing ways to access academic adjustment or accommodations. The student-athlete may need a change in his or her class schedule; special arrangements may be required for extended absences, tests, term papers and projects. Many institutions offer “provisional or temporary” accommodations for individuals who have impairments that are short-term in nature – six months or less (such as a broken arm or concussion).  Such accommodations are often accessed through the disability services office.

A more difficult scenario occurs when the student-athlete experiences prolonged cognitive difficulties.  In this case, considerations should include neuropsychological evaluation to: (a) determine the nature and severity of cognitive impairment, and (b) identify the extent to which psychological issues may be present and may be interacting with the cognitive processes.  Institutions can develop a detailed academic plan that specifies the support services available for that student-athlete. The student-athlete can also choose to disclose the documentation to the disability office in order to seek long-term accommodations or academic adjustments*.* The disability office will verify if the impairment is limiting a major life activity per the Americans with Disabilities Act. Accommodations or academic adjustments are often provided in order to ‘level the playing field’ for the student-athlete with prolonged cognitive difficulties resulting from a concussion.  A detailed academic plan coupled with accommodations can provide the needed support for a student-athlete as he or she returns to learning after a concussion.

The successful implementation of return-to-learn depends on several variables:

* Recognition that concussion symptoms vary widely among student-athletes, and even within the same individual who may be suffering a repeat concussion.
* Identification of a point person or case manager for the student-athlete who can navigate the dual obligations of academics and athletics.
* Identification of co-morbid conditions that may impair recovery, such as migraine or other headache conditions, attention-deficit hyperactivity disorder, anxiety and depression, or other mood disorders.
* Identification of campus resources that can help assure that student-athletes are provided their full rights during this transition period.

Campus resources vary, and may include the following:

* *Learning specialists.* Many college campuses have certified learning specialists who have specialized knowledge of medical conditions such as concussion and post-concussion syndrome.  They usually work directly with the disability office.
* *Office of disability services.* Most campuses have a disability office that is responsible for verifying each student’s impairment under the Americans with Disabilities Act Amendments Act (ADAAA).  Sometimes there is a separate disability office and ADAAA office.  In this case the first resource is the campus disability office.  Concussion and mild traumatic brain injury are covered under ADAAA.

It is advisable for the concussed student-athlete’s medical team to identify an academic point person and to be certain this academician is interwoven into the medical management plan.  Because return-to-learn is often under-managed and under-recognized, there should also be broad discussions of this important paradigm with athletics departments across the country, engaging organizations such as the National Association of Academic Advisors for Athletics, the American College Personnel Association, NASPA, Student Affairs Administrators in Higher Education, the Coalition on Intercollegiate Athletics, National Athletic Trainers Association, College Athletic Trainers Society, American Medical Society for Sports Medicine and other allied organizations.  Student-athletes are more likely to return successfully to full classroom activity in the setting of a proactive and well-integrated management plan.

**References:**

1. Carney N, Ghajar J, Jagoda A et al. Concussion Guidelines Part 1: Systematic review of prevalent indicators.  *Neurosurgery*, accepted in press.
2. McCrory P et al.  Consensus statement on concussion in sport: the 4th International Conference on Concussion in Sport held in Zurich, November 2012.  *Br J Sports Med* 2013; 47:250-258.
3. NCAA Sport Science Institute Newsletter, Vol 1, Issue 2, 2013.
4. NCAA Sport Science Institute Newsletter, Vol 1, Issue 4, 2013.
5. NCAA Sport Science Institute Newsletter, Vol 1, Issue 6, 2013.
6. NCAA Sport Science Institute Newsletter, Vol 1, Issue 7, 2013.
7. NCAA Sport Science Institute Newsletter, Vol 2, Issue 3, 2014.
8. Torres DM et al. Sports-related concussion: anonymous survey of a collegiate cohort.*Neurol Clin Pract*2013; 3:279-287.
9. Kroshus E et al. NCAA concussion education in ice hockey: an ineffective mandate. *Br J Sports       Med*2013; 48:135-140.
10. 2013-14 NCAA Sports Medicine Handbook.
11. Makdissi et al.  Revisiting the modifiers: how should the evaluation and management of acute concussions differ in specific groups.  *Br J Sports Med* 2013; 47:314-320.
12. Broglio SP et al.  National Athletic Trainers’ Association position statement: management of sport concussion.  *J Athl Train* 2014; 49:245-265.
13. Putukian M.  Psychological response to injury: mental health issues.  Presented at NCAA Mental Health Task Force, November 2013.
14. Harmon KG et al. American Medical Society for Sports Medicine position statement: concussion in sport. *Br J Sports Med* 2013; 47:15-26.
15. Giza CC et al. Summary of evidence-based guideline update: Evaluation and management of concussion in sports. *Neurology*2013; 80:2250-2257.
16. McCrea M et al. Effects of a symptom-free waiting period on clinical outcome and risk of reinjury after sport-related concussion. *Neurosurgery* 2009; 65:876-883.
17. Guskiewicz K, Putukian M.  Standardized assessment and return to play. *Safety in College Football Summit.* Presented January 23, 2014, Atlanta, GA.
18. Centers for Disease Control and Prevention: Returning to school after a concussion: a fact sheet for school professionals. <http://www.cdc.gov/concussion/pdf/TBI_Returning_to_School-a.pdf>.
19. Halstead ME et al:  Returning to learning following a concussion.  *Pediatrics* 2013; 132:948-957.
20. Moser RS et al.  Efficacy of immediate and delayed cognitive and physical for treatment of sports-related concussion.  *J Pediatr*2012; 161:922-926.

**\*This Consensus Best Practice, Diagnosis and Management of Sport-Related Concussion, has been endorsed by:**

* American Academy of Neurology
* American College of Sports Medicine
* American Association of Neurological Surgeons
* American Medical Society for Sports Medicine
* American Orthopaedic Society for Sports Medicine
* American Osteopathic Academy for Sports Medicine
* College Athletic Trainers’ Society
* Congress of Neurological Surgeons
* National Athletic Trainers’ Association
* NCAA Concussion Task Force
* Sports Neuropsychological Society

**IV - APPENDIX - Department Policies**

**Athletic Training Policy & Procedure for Concussion**

The Marymount University Sports Medicine team uses a variety of different tools to establish our concussion protocol and return to play criteria. Each student athlete participating in contact sports will complete baseline testing using a computerized concussion management system (ImPACT). In addition to this system, the sports medicine team will use a variety of tools for assessment of concussions and determining return to play. These tools include the Glascow Coma Scale, the Sport Concussion Assessment Tool (SCAT3[Appendix M]); BESS/balance assessment, ocular motor testing, and other functional and cognitive testing.

If there is a suspected neck or spinal cord injury, the athlete should **not** be moved unless there is eminent danger to the athlete and /or rescue personnel. C-spine stabilization will be maintained while an assessment is performed. The athlete with a suspected neck or spinal cord injury will be transported to the nearest hospital by EMS and the team doctor will also be called.

If a team travels without an athletic trainer, coaches should be aware of the different signs and symptoms of a possible concussion and cervical spine injury. Please refer to the “Emergency Procedures” section on page 19 of this manual. Additional information on head injuries will be located in each medical kit (see Athletic Training Manual Appendix N).

**Concussions and other brain injuries can be serious and potentially life threatening injuries in sports. Research shows that these injuries can also have serious consequences later in life if not properly managed. The following Concussion Management Protocol will be used for MU student-athletes suspected of sustaining a concussion.**

A ***concussion*** is a brain injury that (definition taken from the Centers for Disease Control and Prevention):

 Is caused by a blow to the head or body from contact with another player, hitting a hard surface such as the ground, ice or floor, or being hit by a piece of equipment such as a bat, lacrosse stick, or field hockey ball. Can change the way your brain normally works

Can range from mild to severe

Presents itself differently for each student-athlete

Can occur during practice or competition in ANY sport

Can happen even if you do not lose consciousness

As a result, transient impairment of mental functions such as memory, balance/equilibrium, and vision may occur. Again, it is important to bear in mind that many sport-related concussions *do not* result in loss of consciousness and, therefore, all suspected head injuries should be taken seriously.

**Coaches and fellow teammates can be helpful in identifying those who may potentially have a concussion, because a concussed student-athlete may not be aware of his/her condition or potentially be trying to hide the injury to stay in the game or practice.**

1

Information adapted from: Matthew Gfeller Sport-Related Traumatic Brain Injury Research Center & Division of Sports Medicine. August 1, 2010. The University of North Carolina at Chapel Hill Sport Concussion Policy. Retrieved from http://www.ncaa.org/wps/portal/ncaahome?WCM\_GLOBAL\_CONTEXT=/ncaa/NCAA/Academics+and+Athletes/Personal+Welfare/Health+and+Safety/Concussion

**PART ONE**:

Marymount University’s concussion management begins with ***pre-season baseline testing***, using the ImPACT neurocognitive assessment tool. The computerized ImPACT test will be administered for every new (first-year or transfer) student-athlete. The Sport Concussion Assessment Tool 3 (SCAT-3) and Balance Error Scoring System (BESS) will also be administered during the baseline assessment. In the event of a suspected concussion, the student- athlete will be re-assessed and compared to pre-season baseline measures according to the management protocol. Each certified athletic trainer will keep a copy of baseline SCAT and BESS scores for easy access for off campus practices and away competitions.

**PART TWO**:

Any student-athlete suspected of sustaining a concussion will be immediately removed from practice/competition and evaluated by a MU Certified Athletic Trainer using the:

Sport Concussion Assessment Tool 2 (SCAT-3), Balance Error Scoring System (BESS), and a thorough physical exam will be performed.

Should the MU Certified Athletic Trainer not be present (i.e. in cases of away competitions), the student-athlete suspected of sustaining a concussion will be immediately removed from practice/competition and not allowed to return to activity for the remainder of that day (see Part Three). The coach, in turn, will notify the MU Certified Athletic Trainer, as soon as possible. Direct communication with the Student Health Center (SHC) and team physician will be made by the MU Certified Athletic Trainer, Ideally, an assessment of symptoms will be performed at the time of the injury and then serially thereafter (i.e. 2-3 hours post-injury, 24 hours, 48 hours, etc.). The presence or absence of symptoms will dictate the inclusion of additional neurocognitive and balance testing.

**PART THREE**:

**Any student-athlete diagnosed with a concussion *shall not return* to activity for the remainder of that day**. Medical clearance will be determined by the MU Certified Athletic Trainers based on the protocol and if any worrisome symptoms or if patient’s symptoms are more prolonged, the team physician will be notified and patient will be seen by the team doctor.

**PART FOUR**:

If requested by the University physician (or designee) or MU certified athletic trainer (typically for the purpose of evaluating whether an athlete should return to class, reschedule exams, etc.), testing may be conducted while the student-athlete is still symptomatic.

**PART FIVE**:

If the student-athlete has not returned to normal functioning compared to baseline scores upon post-injury testing, follow-up appointments will be scheduled at a time deemed appropriate by the University physician (or designee), athletic trainer, and Student Health Center staff. In the rare event that a student-athlete does not have baseline scores, age-matched normative percentile scores will be used for comparison to post-injury scores.

**PART SIX**:

The following assessment and return to play plan will be used for all concussions:

**NO STUDENT-ATHELTE SUSPECTED OF HAVING A CONCUSSION IS PERMITTED TO RETURN TO PLAY THE SAME DAY, AND NO STUDENT-ATHLETE IS PERMITTED TO RETURN TO PLAY WHILE SYMPTOMATIC FOLLOWING A CONCUSSION. NOTE AFTER BEING DIAGNOSED WTIH A CONCUSSION THE SOONEST AN ATHLETE CAN RETURN TO FULL COMPETITION IS ONE WEEK (PT MUST BE ASYMPTOMATIC FOR THAT ENTIRE WEEK, PASS ALL APPROPRIATE TESTING, AND HAVE A NORMAL EXAM)**

***Prior to the sports season*:**

Baseline testing will be conducted on each student-athlete (first-years and transfers) and for those student- athletes sustaining a concussion the previous season (re-baseline).

***Time of Injury*:**

Initial clinical evaluation will be performed (i.e. symptom checklist, SCAT-3, etc.) at the time of injury.

Follow-up evaluation will be performed 1-3 hours post-injury and a referral made to the ER if necessary for imaging.

***Post-Injury*:**

Follow-up clinical evaluations will be made the next day and subsequent daily checks to track symptom recovery. A post-injury ImPACT test will be administered 24-48 hours after initial injury unless patient is too symptomatic to participate.

Once a student-athlete is asymptomatic, evaluation will take place to determine where student-athlete is relative to following baseline measures:

1. Symptom Assessment
2. Mental Status Assessment (SCAT-3)
3. Neuropsychological Assessment (ImPACT)
4. Balance Assessment (BESS) and full neurological/ocular motor exam

If the measures listed are better than or have to return baseline scores and the student-athlete remains asymptomatic for **one additional day** following these tests, the athletic trainer will begin the graduated return to play (RTP) protocol, assessing for increasing signs and symptoms. Symptoms should be reassessed immediately following exertional activities. If at any point the student-athlete becomes symptomatic during the RTP protocol, he/she will return to the previous asymptomatic level and try to progress again after a further 24-hour period of rest has passed. In some cases the team physician will allow athletes to start light cardio before completely asymptomatic, this is permitted with clearance from the team physician.

**Graduated Return-to-Play Protocol**

**Stage One (48 hours)**

*Rehabilitation Stage*: No activity

*Functional Exercise*: Complete physical and cognitive rest

*Objective*: Recovery

**Stage Two**

*Rehabilitation Stage*: Light aerobic exercise

*Functional Exercise*: Light walking, swimming, or stationary cycling, keeping intensity to < 70% of maximum predicted heart rate; no resistance training

*Objective*: Increase heart rate

**Stage Three**

*Rehabilitation Stage*: Sport-specific exercise

*Functional Exercise*: Skating drills in ice hockey, running drills in soccer; no head impact activities

*Objective*: Add movement

**Stage Four**

*Rehabilitation Stage*: Non-contact training drills

*Functional Exercise*: Progression to more complex training drills, e.g. Passing

drills in football and ice hockey; may start progressive resistance training

*Objective*: Exercise, coordination, and cognitive load

**Stage Five**

*Rehabilitation Stage*: Full-contact practice

*Functional Exercise*: Following medical clearance, participate in normal training activities

*Objective*: Restore athlete’s confidence; coaching staff assesses functional skills

**Stage Six**

Rehabilitation Stage: Return to play

Functional Exercise: Normal game play

**Function and Assessment of Cranial Nerves**

Nerve Name Assessment

I Olfactory Sense of smell

II Optic Peripheral vision, papillary reflex to light

III Oculomotor Pupil size, papillary reflex to light (consensual & direct reflex)

 Raise eyelid

 Eye Movement

IV Trochlear Eye Movement (ability to look up and in)

V Trigeminal Clench teeth, side-to-side jaw movement

VI Abducens Lateral Eye Movement

VII Facial Wrinkle forehead, smile, frown

VIII Vestibulocochlear Tinnitus, hearing, equilibrium (Romberg test)

IX Glossopharyngeal Sense of taste, gag reflex

X Vagus Voice quality

XI Spinal Accessory Shoulder shrug

XII Hypoglossal Stick tongue out, note any deviation to one side

**IV - APPENDIX - Department Policies**

**Concussion Management and Class Absence**

**Shared Policy between Marymount University**

**Student Health Center (SHC) and Athletic Training (AT) Department**

Marymount student athletes present initially to the Athletics Training Department for a concussion related injury. The Athletic Trainer (AT) will diagnose a concussion based on the history of events in conjunction with the SCAT III questionnaire. A plan of care will be established by the AT for the student to undergo daily SCAT III checks with the AT. Students with concussion will see the team physician during weekly doctors hours or in her office sooner if needed.

The AT will email the Student Health Center and the Dean of Student Success to the history of events and develop a plan for class attendance. The student will be copied on this email to ensure clear communication of next steps.

An example of an email template from AT would be:

 *I have referred (insert student name) to the SHC and the Student Affairs office given the recent concussion diagnosis. (Insert student name) will contact both offices within the next 24 hours to establish a meeting to review medical and academic concerns. (Insert student name) will follow-up with AT tomorrow.*

 *For your convenience (insert student name) I have included contacts for the two offices below:*

*SHC Contact:* *shealthc@marymount.edu*

*Student Affairs Contact:* *studentaffairs@marymount.edu*

If a student athlete has symptoms associated with a concussive event and is unable to attend classes, class absences will be arranged through the Student Health Center (SHC). The SHC will work with the Dean of Student Success as well as the athletic trainer to coordinate and manage class absences on a case-by-case basis.

The Athletic Trainer and team physician will make the formal decision as to whether the student is eligible to participate in sports. If the SHC has a concern they will contact the Head Athletic Trainer or team physician directly.

 Established July 2014

**IV - APPENDIX - Department Policies**

**Student Health Center (SHC)**

Protocol – Concussion

1. **CONDITION FOR PROTOCOL**: To evaluate and manage students who have suffered a concussion or concussive-like injury.
2. **POLICY OF PROTOCOL**: The Registered Nurse or Nurse Practitioner will initially implement this protocol for concussion evaluation and management using the Sport Concussion Assessment Tool (SCAT III).
3. **CONDITION SPECIFIC CRITERIA AND PRESCRIBED ACTIONS**:
	1. The University physician will medically clear the student.
	2. Class absences, if deemed appropriate, will be arranged through the Student Health Center Director.
4. **IMPORTANT CONSIDERATIONS**
	1. Concussions can occur even without loss of consciousness.
	2. Symptoms may last from hours to weeks depending on the severity of the injury and the management of symptoms.
	3. The best initial treatment for a concussion is rest – both of the body and brain.
	4. For student athletes implement a gradual return to play (5 day minimum).
	5. Avoid use of NSAIDS. Can use Tylenol sparingly.
	6. Symptoms may include:
		1. Amnesia
		2. Confusion
		3. Headache
		4. Feeling sluggish, foggy or groggy
		5. Irritability
		6. Concentration or memory problems
		7. Loss of consciousness
		8. Balance problems or dizziness
		9. Double or fuzzy vision
		10. Sensitivity to light or noise
		11. Nausea
5. **ADMINISTRATION AND ACUTE MANAGEMENT**:
	1. Take a good history. Send to ER if any of the following positive:
		1. Loss of consciousness > 1 minute
		2. Vomiting or nausea
		3. Change In mental status (GCS < 13)
		4. Spinal injury
	2. Most important is neurological exam. Using SCAT III provider will complete:
		1. Glascow coma scale (if patient speaking and has appropriate eye contact score automatically 15)
		2. Background (important to pay attention if patient has history of a learning disability, depression or anxiety)
		3. Cognitive assessment (orientation and 3-5 word immediate memory recall)
		4. Neck examination (ROM, tenderness, upper and lower limb sensation and strength)
		5. Coordination exam (finger to nose)
		6. SAC delayed recall (delayed recall score of 3-5 words from cognitive assessment)
	3. Student will complete 22 symptom evaluation. Important to assess what normal baseline for student is regardless of concussion symptoms.
	4. Student will return to SHC every 2 days to complete a follow-up 22 symptom evaluation.
	5. Provide student with copy of What is a Concussion Information sheet, to include prescribed treatment recommendations and advise for worsening symptoms.
	6. Advise patient to seek emergency medical attention for a new severe headache, vomiting, new numbness or weakness, new mental status changes or new concerning symptoms

 References:

[www.bjsm.bmj.com](http://www.bjsm.bmj.com), February 19, 2014, SCAT 3 Sport Concussion Assessment Tool – 3rd edition

 Klossner, David, MD, Anderson, Jeff, MD, NCAA Committee on Competitive Safeguards and Medical Aspects of Sports, NCAA Regional Rules Meeting, May-June 2012

Usman, Saif, MD, MedStar Georgetown University Hospital, Marymount University physician

**QUESTIONS OR CONCERNS:**

In the event of questions or concerns call Dr. Usman (917.297.7412)

This protocol shall remain in effect for all patients of Marymount University Student Health Center until rescinded or until \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Name of prescriber:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

 Rev 5/4/15

**IV - APPENDIX - Department Policies**

**Spirit Programs Concussion Management and Care Protocol**

A concussion is defined as complex injury which is often induced by biomechanical forces during a variety of physical activities. Concussions may manifest through a variety of physical, cognitive and behavior symptoms. As a result, appropriate management and care is vital in order to prevent serious and potentially life-threatening complications. It is important to note that all concussions are not the same which is why each case should be treated individually. Concussive injuries occur with varying levels of severity, as well as a variety of signs and symptoms.

The recommendations for this protocol was developed from the American Association of Cheerleading and Administrator’s “Guidelines for post-concussion Rehab”, The University of Risk Management and Insurance Association’s Journal report entitled “Concussion Management: student athlete and institutions Protection (2014)” and the National Athletic Training Association’s Position Statement: Management of Sport-Related Concussions. This protocol should be used as a guide for the response and management of all head injuries or suspected concussions to any current or perspective Marymount University cheer or dance team members.

Marymount University cheer and dance team coaches are responsible for ensuring that all team practices, performances and competitions activities are safe. Similarly, all cheer and dance team members are expected to act in a safe and responsible manner at all Spirit Programs try-outs, practices and performance activities. The Marymount University Spirit Programs Policy regarding the management and care of cheer-leading and dance team related concussion events is as follows:

**Pre-participation requirements**

All prospective cheer and dance team members are required to have an annual pre-participation physical evaluation completed prior to participating in any cheer or dance team tryouts, practices or performances. This evaluation must be submitted to the Student Health Center where a medical clearance must be secured prior to participation in any dance or cheer activity. In addition to the Student Health Center, emergency contact information (i.e.: allergies/parent contact information) will be maintained in the Lee Center Manager’s office.

Dance/cheer coaches along with dance and cheer team members are required to attend pre-participation education/training about concussions. In addition to in person training, a mandatory on-line course will be provided for all coaches and team members. All participants must sign a training completion form to verify that they understand the content of the training.

**Injury Evaluation and Care**

Any Marymount cheer or dance team member who sustains a suspected head injury or concussion must be immediately REMOVED FROM PLAY and directed for immediate medical evaluation. The team coach will follow the MU policy for emergency and non-emergency transportation to ensure the student is safely and promptly gets medical attention. (See attached)

If the student exhibits any signs, symptoms, or behaviors that are consistent or similar to those listed below then the student should be immediately removed from the activity and shall not return to any team activities until evaluated and cleared by a physician.

**Symptoms that may be reported by cheer or dance team member:**

* Headache
* Nausea
* Balance problems & Dizziness
* Blurred vision
* Sensitivity to bright lights or loud noise
* Feeling “sluggish” or “foggy”
* Altered sleep patterns
* Difficulty concentrating
* Problems with memory

**Signs observed by coaches and or other cheer and dance team members:**

* Stunned or confused appearance
* Forgets arm motions or cheers
* Confused about formations in dances or routines
* Unsure or surroundings (i.e. games scores)
* Moves clumsily
* Loss of consciousness (long or short)
* Personality or behavior changes after a head injury (irritable, agitated, sad, etc.)
* Forgets events right before or after a blow to the head
* Nausea or vomiting
* Neck pain

***Source:*** *The American Association of Cheerleading and Administrators visit* [*http://www.aacca.org/concussions*](http://www.aacca.org/concussions) *for further details.*

**Concussion Management and Referral**

Any student who sustains a head injury is required to report to the Student Health Center immediately and should be accompanied by his/her coach. If the Student Health Center is closed, the cheer or dance team coach should contact Campus Safety (703-284-1600) and request emergency personnel to assess the students injury and if necessary transport the student to a nearby hospital for immediately evaluation.

With any severe pain, significant mechanism of injury, vomiting, lethargy, GCS<15, neck pain, numbness or tingling anywhere, or any symptoms worrisome to the coach or player, the patient should be taken to the hospital for evaluation.

The cheer/dance team coaches and at least one witness must submit an Injury Report Form to the Spirit Programs Coordinator and the Marymount Student Health Center within 24 hours of the injury. The form should include a full description of the event. See attached form.

If a student with concussive symptoms is unable to attend classes, then absences will be arranged through the Student Health Center staff with guidance from the Dean of Student Affairs and the Vice President of Student Affairs.

The Student Health Center staff along with the Dean of Student Affairs and the Vice President of Student Affairs will review the history of events and develop a plan for class attendance if necessary.

The student will be provided with all appropriate communications on the plan to ensure clear understanding of the full scope of the plan.

**Return to Participation**

Once a student has been evaluated, given written clearance from a physician who specializes in concussion management, and has been completely symptom free for at least one week, and completed a return to play protocol, then he/she can return to team activities as recommended by a physician.

**IV - APPENDIX - Department Policies**

**Student Access Services (SAS)**

SAS Background:

Student Access Services (SAS) provides reasonable accommodations to students with documented disabilities, while also monitoring general campus accessibility and promoting disability awareness across campus. SAS is available throughout the year for information, services, and referrals to complement – but not duplicate – services offered to students through other campus offices.

Eligible students may register for accommodations by providing SAS with the required documents and meeting with the Director of SAS. Although parents and advocates may assist students with this introduction, the Director will not be able to determine accommodations for a student without their attendance at meetings and active involvement in the process. Also, for legal reasons, any medical documents that have been submitted to the Admissions Office or Student Health Services will not be automatically sent to SAS. Students requiring SAS accommodations must ensure that SAS receives their documents and forms directly.

SAS Concussion Policy:

Per the NCAA recommended guidelines SAS would not be automatically solicited for the review of medical documentation for disability accommodations for short-term head injuries, unless the injury led to longer-term implications for the student's academics. The SAS office may receive notifications of concussions and temporary injuries, from a variety of sources across campus but will not be able to act on these notifications without contact from the student involved. Either SAS or the Dean of Student Success will function as the point of contact or academic case manager as required.

Short Term Process: For short-term student concussion symptoms, the Head of Sports Medicine email communication and the Dean of Student Success "Emergency Absence Notification Letter" prompt instructors to flexible with these student's on class absences and missed exams/late assignments. For these students, temporary absences, temporary elevator access, and the like, do not need to go through the SAS office. These kinds of needs can be addressed through other MU offices, without the student having to go through the documentation review and accommodation approval process that has to be followed by SAS.

Long Term Process: As stated in the return-to-learn guidelines, longer than expected recovery times may result in the need for ADA accommodations and support services or more "meaningful curriculum or testing alterations", such as additional time to complete in-class exams, or an introduction to speech-to-text technology. In these cases, once an injured student has been referred to SAS by the Dean of Student Success and the Head of Sports Medicine has provided medical documentation, SAS will generate a "Faculty Contact Sheet" for the student to e-mail or hand-in to their instructors. The Faculty Contact Sheet lists the student's approved accommodations, based on the medical authorities and it has to be signed by the student. This can be accomplished in one 1-hour SAS appointment. Students must make the appointment via Starfish (in Blackboard or Canvas) or there is a scheduling kiosk at the CTL front desk that our student workers have been trained to help students use. Also, information on how to use each approved accommodation is explained to the student directly and made available on MU's website and in handouts at the CTL front desk in Rowley G105.