

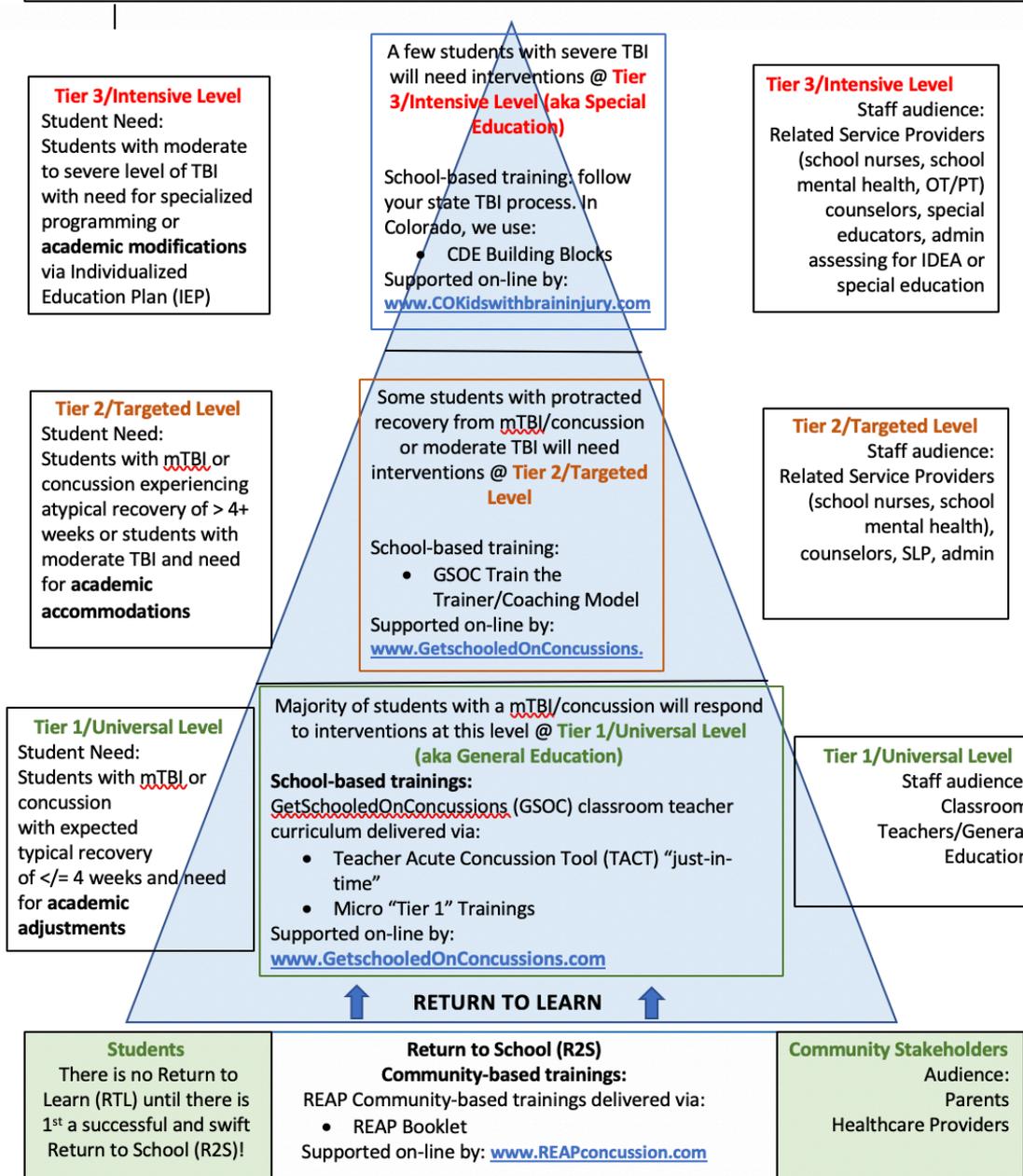
Nebraska Dept of Education  
October 21, 2019



# Return to Learn (RTL)

19            (c) Establish a return to learn protocol for students  
20 that have sustained a concussion. The return to learn protocol shall  
21 recognize that students who have sustained a concussion and returned  
22 to school may need informal or formal accommodations, modifications  
23 of curriculum, and monitoring by medical or academic staff until the  
24 student is fully recovered.

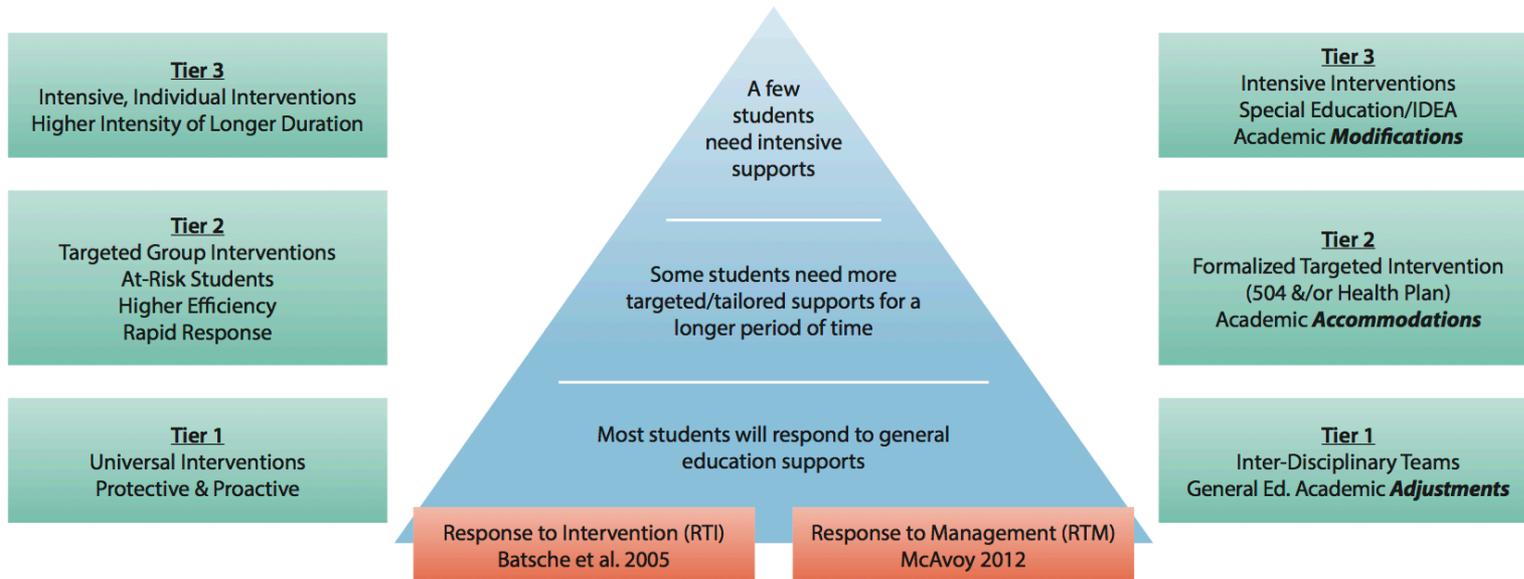
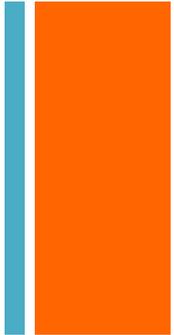
Return to Learn: A Schooled-Based and School-Directed RTL Protocol





# Ascending Levels Universal Level

## Multi-Tier System of Support (MTSS)



### *Differentiated instruction*

Academic: Adjustments (days to weeks) vs. Accommodations (weeks to months)  
vs. Modifications (months to years)

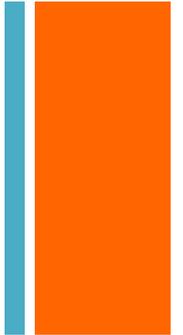
## + Lets recap...What do we know about the “typical” concussion?

A concussion is a short-term transient injury that causes functional impairment for **days** to **weeks**. Recovery from concussion for 70% of kids/adolescents is **28 days** (Zemek, 2016)

It is acceptable for a student to miss a few days of school but typically kids will be back at school within 2 - 4 days to 1 week (Halstead, 2013; Thomas, 2015)

While students may be back at school, academic dysfunction may last up to 1 month (Wasserman, 2016)

However, in the end, especially if handled well, there are (rarely) long-term grade/credit (transcript) consequences (Russell, 2015)





# PEDIATRICS®

OFFICIAL JOURNAL OF THE AMERICAN ACADEMY OF PEDIATRICS

When symptoms are “tolerable, intermittent and amenable to rest”

## **Returning to Learning Following a Concussion**

Mark E. Halstead, Karen McAvoy, Cynthia D. Devore, Rebecca Carl, Michael Lee, Kelsey Logan and Council on Sports Medicine and Fitness, and Council on School Health

*Pediatrics*; originally published online October 27, 2013;  
DOI: 10.1542/peds.2013-2867

The online version of this article, along with updated information and services, is located on the World Wide Web at:

<http://pediatrics.aappublications.org/content/early/2013/10/23/peds.2013-2867>

# + So...where does concussion management really happen?



**YES!** In the general education classroom!

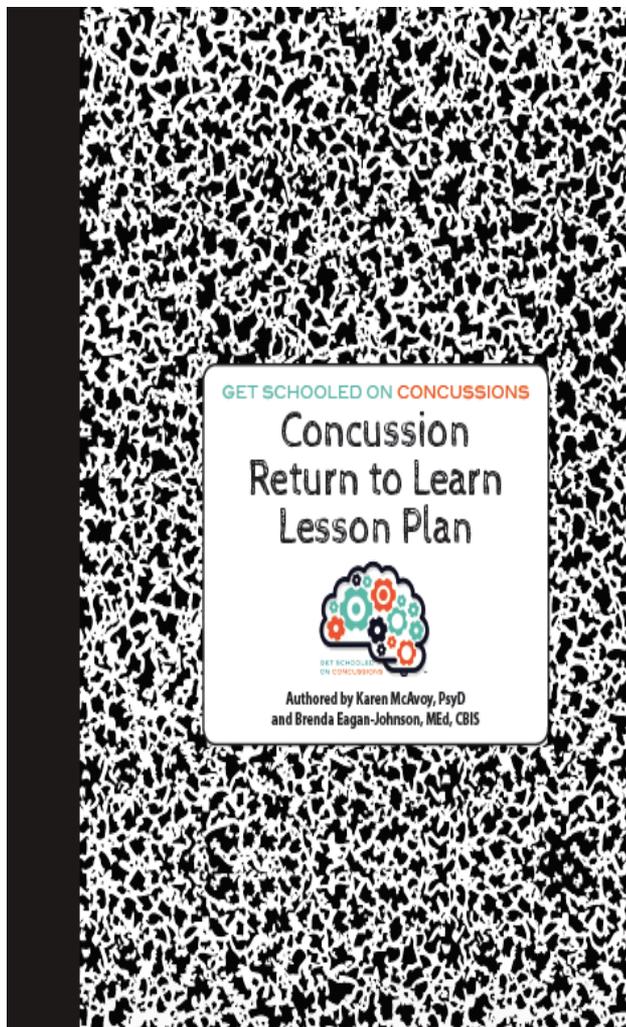
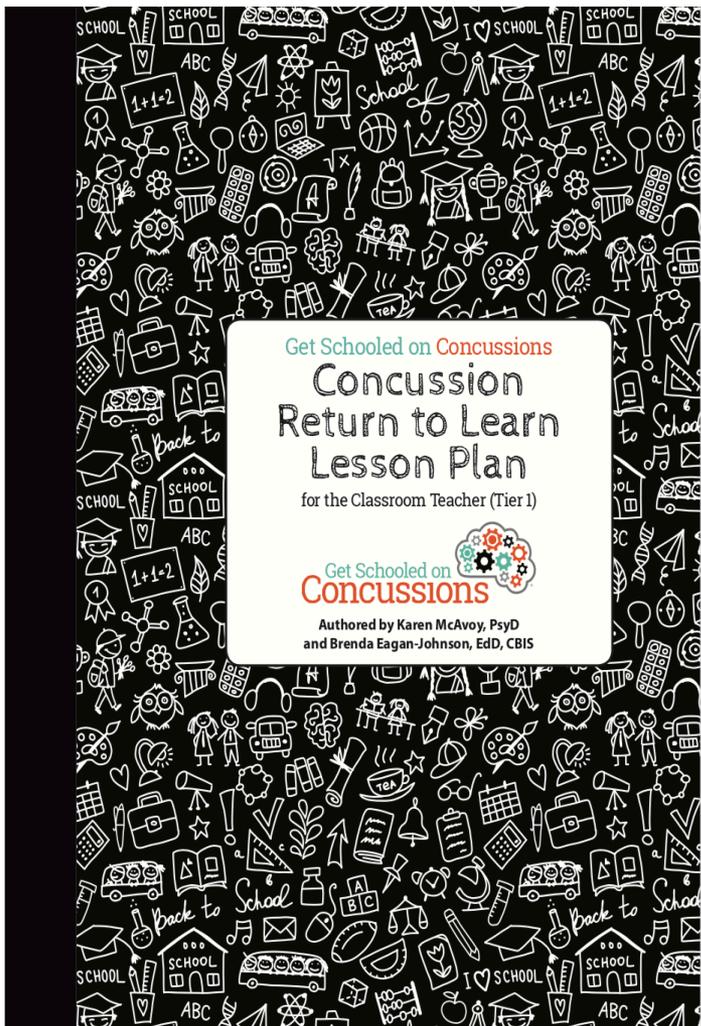
(Fortunately) the majority of concussions are not a 504 issue or an IEP issue!

**Good concussion management = quick, flexible, short-term, academic “adjustments”**

**(not accommodations aka 504 nor modifications aka Special Ed)**

**But if recovery has not been achieved within 4 to 6+ weeks:**

**These students should be referred to a higher level of support (that’s covered in the T the T model)!**

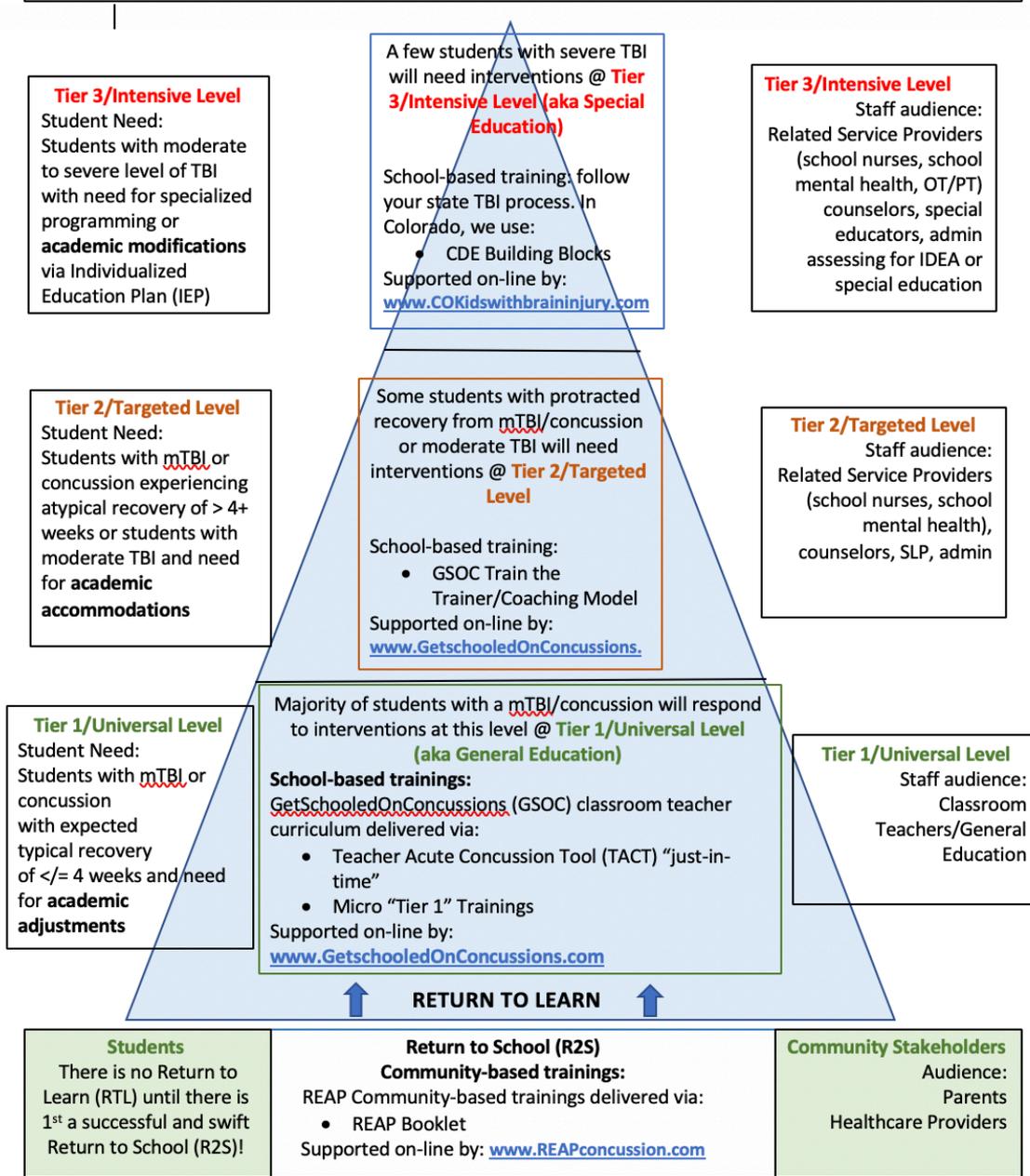


- ✓ What to do in the classroom?
- ✓ What to do about missed instruction?
- ✓ What to do about make-up work?
- ✓ What to do about quizzes/test?
- ✓ What to do about extracurricular activities?



# **Are YOU Ready to Get Schooled On Concussions?**

Return to Learn: A Schooled-Based and School-Directed RTL Protocol



# + Second Impact Syndrome (SIS)

## Athlete suffered trauma to head

By David Montero  
ROCKY MOUNTAIN NEWS

The high school football player who collapsed and died on the field during a game in Aurora this weekend suffered a closed-head injury, an autopsy revealed Monday.

However, officials with the Arapahoe County Coroner's Office said the full results will not be known until all laboratory testing is complete.

Jacob Snakenberg, a 15-year-old freshman fullback for Grandview High School, had just carried the ball during the game against Denver's Thomas Jefferson High School on Saturday when he suddenly collapsed. He died Sunday at Swedish Medical Center.

Dr. John McVicker, the neurosurgeon who operated on Snakenberg, said the teenager's injury was fatal because of another recent trauma to his head. McVicker said Snakenberg suffered from second-impact syndrome and that symptoms often include forgetfulness, difficulty concentrating or learning and mild headaches.

The Snakenberg family seemed to acknowledge as much in a state-



ment Monday evening.

"Jake died playing football with all his heart and may not have listened to his body telling him he was hurt," the statement read. "Probably as a consequence of a second head injury with subsequent rapid brain swelling, he died in less than one day in

spite of optimal treatment."

Snakenberg's mother also addressed the football team Monday morning, according to Cherry Creek School District spokeswoman Tustin Amole. [http://www.rockymountainnews.com](#)



**Grandview High School students** gather Monday at the spot on the football field where freshman fullback Jacob Snakenberg, left, collapsed Saturday. Doctors said the teen suffered from second-impact syndrome.

BARRY GLUTIERREZ/ROCKY MOUNTAIN NEWS

Click to PLAYER on 21A

# Second Impact Syndrome

Phenomenon of still being symptomatic from a concussion, receiving another blow to the head (while symptomatic, this is not about multiple sequential concussions) and having a cascade of catastrophic metabolic events resulting in serious brain damage or death.



Nebraska  
Concussion  
Coalition

Changing the culture of  
concussion awareness and management  
in Nebraska

How every family, school and medical professional can implement a  
Community-Based Concussion Management Program

## REAP<sup>®</sup> The Benefits of Good Concussion Management

# REAP<sup>®</sup>

**Remove/Reduce**  
**Educate**  
**Adjust/Accommodate**  
**Pace**

Authored by Karen McAvoy, PsyD

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A soccer player in a grey jersey and black shorts is captured in mid-air, performing a powerful kick. The player's right leg is extended forward, with the foot striking a black and white soccer ball. The player's left leg is bent and tucked under. The background is a bright blue sky with scattered white clouds, and the foreground is a lush green soccer field with white markings. The overall scene conveys a sense of dynamic action and athletic performance.

# REAPconcussion.com

REAP is a community-based concussion management approach that stands for:

- **Remove/Reduce**
- **Educate**
- **Adjust/Accommodate**
- **Pace**



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# National RTP/RTS Return to Play/Sport Legislation

Last updated: 2/19/2014



Source: National Conference of State Legislatures, 2013.<sup>6</sup>

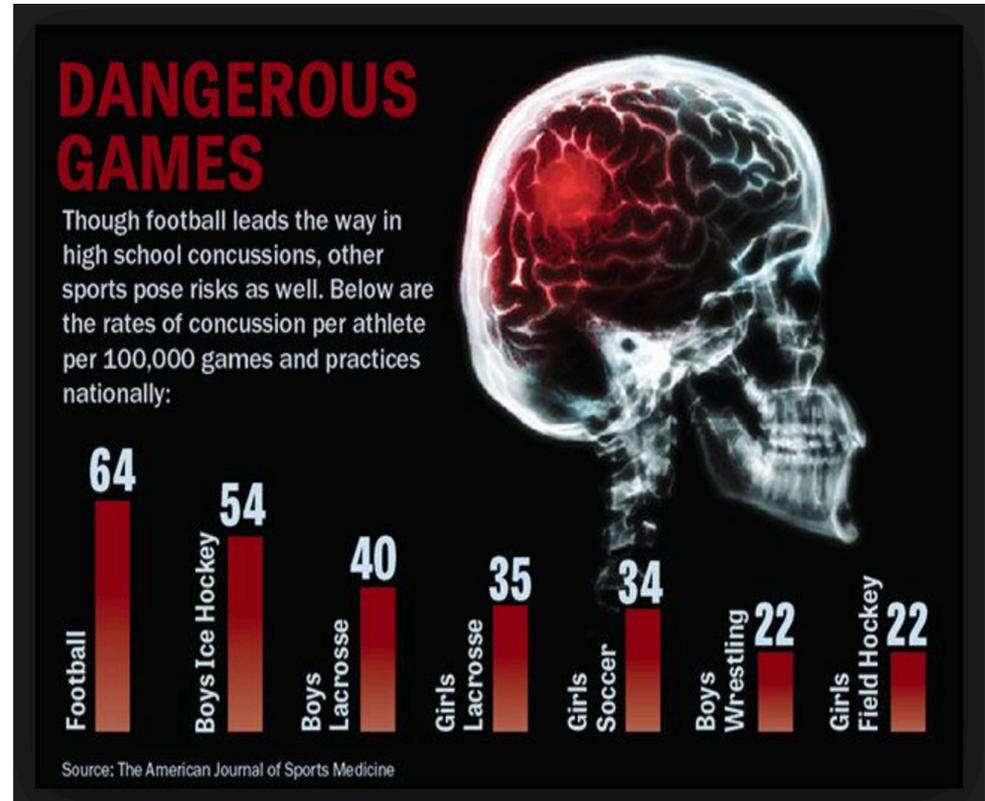
Most concussion in sports laws include three action steps:

1. **Educate Coaches, Parents, and Athletes:** Inform and educate coaches, athletes, and their parents and guardians about concussion through training and/or a concussion information sheet.
2. **Remove Athlete from Play:** An athlete who is believed to have a concussion is to be removed from play right away.
3. **Obtain Permission to Return to Play:** An athlete can only return to play or practice after at least 24 hours *and* with permission from a health care professional.



Here are the facts...

Concussions do happen in sports





# Common Concussion Signs/Symptoms

## Physical

Headache  
Nausea/Vomiting  
Balance Problems  
Visual Problems  
Fatigue  
Sensitivity to Light and Noise  
Dazed/Stunned

## Emotional

Irritable  
Sadness  
Nervous  
More emotional

## Cognitive

Feeling mentally “foggy”  
Feeling slowed down  
Difficulty concentrating  
Difficulty remembering  
Confusion about recent events  
Slowly answering questions  
Repeats questions

## Sleep

Drowsiness  
Sleeping more than usual  
Sleeping less than usual  
Difficulty falling asleep



# Harry Potter Sustained An Astoundingly Dangerous Number Of Concussions

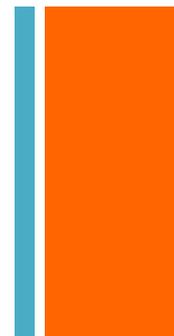
“Harry felt as if his head had been split in two.”



**BUT ... 40% +** are concussions are from non-sports related activities  
(Eagan-Brown, BrainSTEPS)



# All students have to Return to Learn Nebraska Law



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23 of curriculum, and monitoring by medical or academic staff until the  
24 student is fully recovered.

# Consensus statement on concussion in sport—the 5<sup>th</sup> international conference on concussion in sport held in Berlin, October 2016

Paul McCrory,<sup>1</sup> Willem Meeuwisse,<sup>2</sup> Jiří Dvorak,<sup>3,4</sup> Mark Aubry,<sup>5</sup> Julian Bailes,<sup>6</sup> Steven Broglio,<sup>7</sup> Robert C Cantu,<sup>8</sup> David Cassidy,<sup>9</sup> Ruben J Echemendia,<sup>10,11</sup> Rudy J Castellani,<sup>12</sup> Gavin A Davis,<sup>13,14</sup> Richard Ellenbogen,<sup>15</sup> Carolyn Emery,<sup>16</sup> Lars Engebretsen,<sup>17</sup> Nina Feddermann-Demont,<sup>18,19</sup> Christopher C Giza,<sup>20,21</sup> Kevin M Guskiewicz,<sup>22</sup> Stanley Herring,<sup>23</sup> Grant L Iverson,<sup>24</sup> Karen M Johnston,<sup>25</sup> James Kissick,<sup>26</sup> Jeffrey Kutcher,<sup>27</sup> John J Leddy,<sup>28</sup> David Maddocks,<sup>29</sup> Michael Makdissi,<sup>30,31</sup> Geoff Manley,<sup>32</sup> Michael McCrea,<sup>33</sup> William P Meehan,<sup>34,35</sup> Sinji Nagahiro,<sup>36</sup> Jon Patricios,<sup>37,38</sup> Margot Putukian,<sup>39</sup> Kathryn J Schneider,<sup>40</sup> Allen Sills,<sup>41,42</sup> Charles H Tator,<sup>43,44</sup> Michael Turner,<sup>45</sup> Pieter E Vos<sup>46</sup>

► Additional material is published online only. To view please visit the journal online (<http://dx.doi.org/10.1136/bjsports-2017-097699>)

For numbered affiliations see end of article.

## Correspondence to

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Accepted 6 March 2017

## PREAMBLE

The 2017 Concussion in Sport Group (CISG) consensus statement is designed to build on the principles outlined in the previous statements<sup>1–4</sup> and to develop further conceptual understanding of sport-related concussion (SRC) using an expert consensus-based approach. This document is developed for physicians and healthcare providers who are involved in athlete care, whether at a recreational, elite or professional level. While agreement exists on the principal messages conveyed by this document, the authors acknowledge that the science of SRC is evolving and therefore individual management and return-to-play decisions remain in the realm of clinical judgement.

This consensus document reflects the current state of knowledge and will need to be modified as new knowledge develops. It provides an overview of issues that may be of importance to healthcare providers involved in the management of SRC. This paper should be read in conjunction with the systematic reviews and methodology paper that accompany it. First and foremost, this document is intended to guide clinical practice; however, the authors feel that it can also help form the agenda for future research relevant to SRC by identifying knowledge gaps.

A series of specific clinical questions were developed as part of the consensus process for the Berlin 2016 meeting. Each consensus question was the subject of a specific formal systematic review, which is published concurrently with this summary statement. Readers are directed to these background papers in conjunction with this summary statement

articles were screened by the expert panels for the Berlin meeting. The details of the search strategies and findings are included in each of the systematic reviews.

The details of the conference organisation, methodology of the consensus process, question development and selection on expert panellists and observers is covered in detail in an accompanying paper in this issue.<sup>5</sup> A full list of scientific committee members, expert panellists, authors, observers and those who were invited but could not attend are detailed in at the end of the summary document. The International Committee of Medical Journal Editors conflict of interest declaration for all authors is provided in Appendix 1.

Readers are encouraged to copy and freely distribute this Berlin Consensus Statement on Concussion in Sport, the Concussion Recognition Tool version 5 (CRT5), the Sports Concussion Assessment Tool version 5 (SCAT5) and/or the Child SCAT5. None of these are subject to copyright restriction, provided they are used in their complete format, are not altered in any way, not sold for commercial gain or rebranded, not converted into a digital format without permission, and are cited correctly.

## Medical legal considerations

The consensus statement is not intended as a clinical practice guideline or legal standard of care, and should not be interpreted as such. This document is only a guide, and is of a general nature, consistent with the reasonable practice of a healthcare professional. Individual treatment will depend on the facts



# 70% ODDS

- **70%** of students with a concussions between the ages of 5 to 18 years will resolve their concussion in 4 weeks

(Zemek, et al. 2016)

PHYSICAL How a Person Feels Physically		COGNITIVE How a Person Thinks	
Headache/Pressure	Nausea	Feel in a "fog"	
Blurred vision	Vomiting	Feel "slowed down"	
Dizziness	Numbness/Tingling	Difficulty remembering	
Poor balance	Sensitivity to light	Difficulty concentrating/easily distracted	
Ring in ears	Sensitivity to noise	Slowed speech	
Seeing "stars"	Disorientation	Easily confused	
Vacant stare/Glassy eyed	Neck Pain		
EMOTIONAL How a Person Feels Emotionally		SLEEP/ENERGY How a Person Experiences Their Energy Level and/or Sleep Patterns	
Inappropriate emotions	Irritability	Fatigue	Drowsiness
Personality change	Sadness	Excess sleep	Trouble sleeping less than usual
Nervousness/Anxiety	Lack of motivation	Trouble falling asleep	
Feeling more "emotional"			



# Rehabilitation



- **Oculomotor** – eyes

Optometry  
Ophthalmology

- **Vestibular** – ears/balance
- **Auditory Processing**

Audiology  
ENT

Vestibular Physical/Occupational Therapy

- **Headaches**

Manual Physical  
Therapy

Muscular/Cervical Strain – Physical  
Therapy

Vascular - Neurology

Sleep

- **Postural Dizziness**

Cardiology

Safe cardio exercise

- **Mood/Behaviors**

Psychology/Psychiatry

CBT  
Lifestyle

# + Longer Recovery?

History of headaches

Family history of migraines

History of past concussions

Learning issues

Attentional issues

History of mental health problems

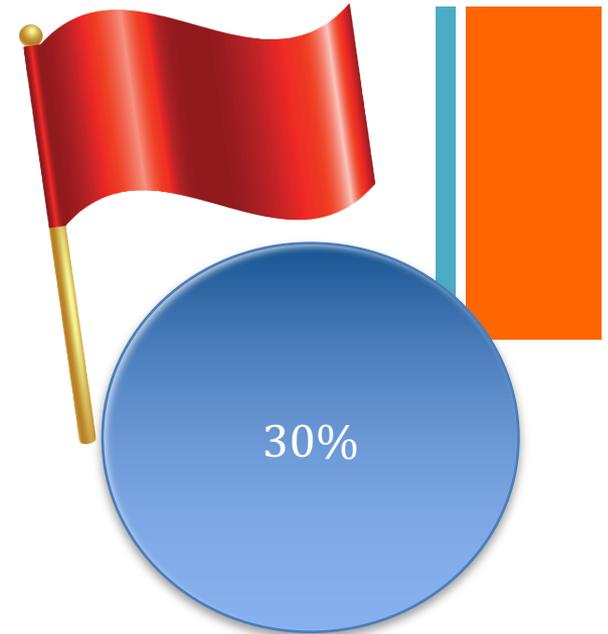
Underlying neurological issues (spectrum)

Underlying psychological issues (anxiety/dep)

(School avoidance/truancy)

History of lazy eye

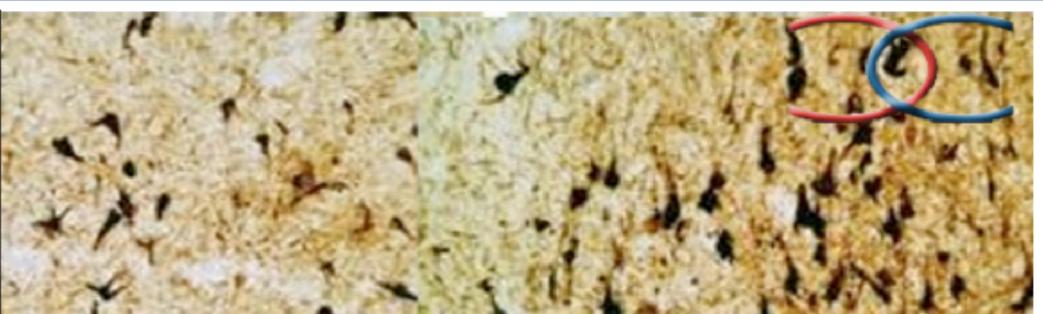
History of Sleep disorder



- Oculomotor
- Vestibular
- Audiology
- Cervical
- Dysautonomia
- Convergence Insufficiency



W I L L S M I T H  
**CONCUSSION**  
IN THEATERS CHRISTMAS DAY



Center for the Study of Traumatic Encephalopathy Now One Year Old



Nebraska  
Concussion  
Coalition

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**Remove/Reduce**  
**Educate**  
**Adjust/Accommodate**  
**Pace**

Authored by Karen McAvoy, PsyD

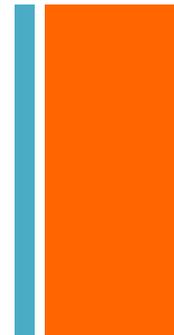
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[www.REAPconcussion.com](http://www.REAPconcussion.com)

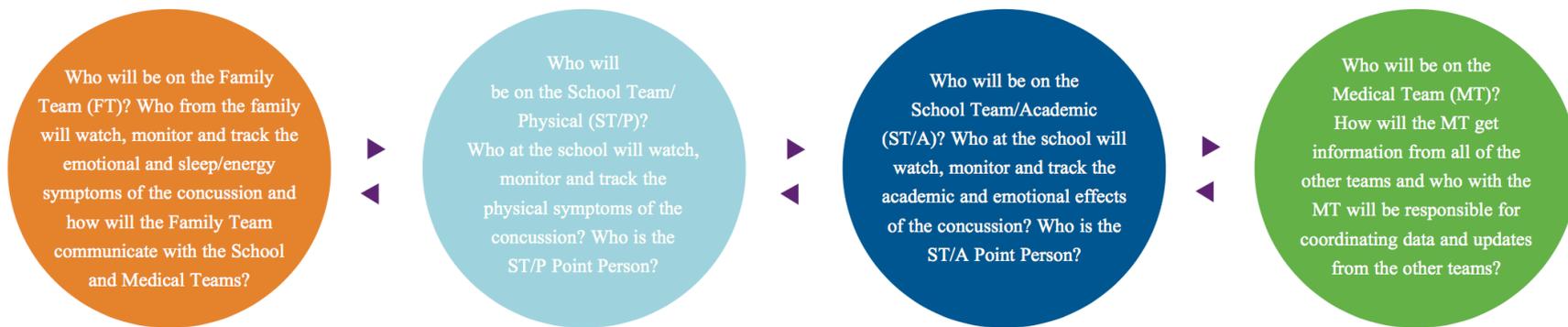


# Every Team and Team Member has an important role!



**There is NO Return to Play/Sport until there is first Return to School, Return to Learn and Return to Doing the Dishes at home!**

An "Interdisciplinary Team" = Adults who provide multiple perspectives of the student/athlete AND who provide multiple sources of data to gauge recovery status



REMOVE/REDUCE

EDUCATE

ADJUST/  
ACCOMMODATE

PACE

SPECIAL  
CONSIDERATIONS

RESOURCES

APPENDIX

## » Once a concussion has been diagnosed:



### Jake Snakenberg

April 19, 1990 – September 19, 2004

In the Fall of 2004, Jake Snakenberg was a freshman football player at Grandview High School. He likely sustained a concussion in a game the week prior, however, he did not fully understand that he had experienced a concussion, and he did not report his symptoms to anyone. One week later, Jake took a typical hit in a game, collapsed on the field and never regained consciousness. Jake passed away from “Second Impact Syndrome” on September 19, 2004.

**STEP ONE: REMOVE** student/athlete from all physical activities.  
**REDUCE** school demands and home/social stimulation.

The biggest concern with concussions in children/teens is the risk of injuring the brain again before recovery. This is called “Second Impact Syndrome,” and it is thought to occur when an already injured brain takes another hit resulting in possible massive swelling, brain damage and/or death<sup>1</sup>. The concussed brain is in a vulnerable state, and even a minor impact can result in a much more severe injury with risk of permanent brain damage, or rarely, even death. Therefore, once a concussion has been identified, it is critical to REMOVE a student/athlete from ALL physical activity, including PE classes, dance, active recess, recreational and club sports until medically cleared.

Secondly, **while the brain is still recovering**, all school demands and home/social stimulation should be reasonably REDUCED (not eliminated completely) and then slowly brought back up over 4 weeks. Reducing demands on the brain will promote REST and will help recovery.

<b>FT</b>	<b>Family Team</b>	REMOVE student/athlete from all physical activity immediately, including play at home (i.e. playground, bikes, skateboards), recreational, and/or club sports. REDUCE or limit home/social stimulation, including texting. Do not totally restrict electronics and social activities; make a reasonable home plan. Encourage REST for the first few days followed by a gradual re-introduction of cognitive, social and home activities.
<b>ST/P</b>	<b>School Team Physical</b>	REMOVE student/athlete from all physical activity immediately. Support REDUCTION of school demands and home/social stimulation. Provide encouragement to REST and take the needed time to heal.
<b>ST/A</b>	<b>School Team Academic</b>	REMOVE student/athlete from all physical activity at school, including PE, recess, dance class. REDUCE or limit school demands. Do not totally restrict academic expectations. (See ADJUST/ACCOMMODATE for Educators on pages 9-10). Encourage “brain REST” breaks at school.
<b>MT</b>	<b>Medical Team</b>	REMOVE student/athlete from all physical activity immediately. RULE-OUT more serious medical issues including severe traumatic brain injury. Consider risk factors – evaluate for concussion complications. Support REDUCTION of school demands and home/social stimulation. Encourage REST for the first few days followed by a gradual re-introduction of cognitive, social and home activities.

**STEP TWO: EDUCATE** all teams that symptoms tell the story of the recovery of the concussion.

**After a concussion**, the brain cells are temporarily inefficient. A helpful way for students, parents and teachers to think of a concussion is as an “energy crisis”; not as something scary like a bruise or a bleed. Here are two energy management scripts to use with your kids/children/teens/students:

“When you have a concussion, you are like an iPhone 4, you are not an iPhone X. You are not broken, you are just not holding a charge long enough.”

“When you have a concussion, you are like a car with a small gas tank. You can get out of the garage (go to school, socialize with friends) but you need to ‘do, then fuel.’ The symptoms function like an indicator light on the car’s dashboard. When they ‘flare’, they are simply a signal of how well you have been managing your energy levels.”

Symptoms become the barometer of the concussion. If symptoms may be present for up to 4 weeks (albeit hopefully decreasing daily/weekly), it is our duty to teach our children how to “pace their energy so they can control their symptoms” – that is the best way for them to stay engaged in school and life while holding symptoms at bay. Learning to manage symptoms is an active approach to rehabilitation! Doing cognitive and home activities in smaller amounts followed by eye/brain/water intake breaks (5 to 10 minutes)... “do, then fuel”... is how the school and home plan can be rehabilitative and not restrictive. It is unreasonable to ask a child/teen to never text or watch TV over 4 weeks. It is unreasonable to ask a teacher to never ask a student to read or look at a computer or complete some in-class schoolwork or homework over 4 weeks. If we want our children/teens/students to be engaged in their own recovery, we have to keep them reasonably engaged in their own lives – socially, academically and at home – while we are waiting for the concussion to heal.



**PHYSICAL**  
How a Person Feels Physically

Headache/Pressure	Nausea
Blurred vision	Vomiting
Dizziness	Numbness/Tingling
Poor balance	Sensitivity to light
Ringing in ears	Sensitivity to noise
Seeing “stars”	Disorientation
Vacant stare/Glassy eyed	Neck Pain

**COGNITIVE**  
How a Person Thinks

Feel in a “fog”
Feel “slowed down”
Difficulty remembering
Difficulty concentrating/easily distracted
Slowed speech
Easily confused

**EMOTIONAL**  
How a Person Feels Emotionally

Inappropriate emotions	Irritability
Personality change	Sadness
Nervousness/Anxiety	Lack of motivation
Feeling more “emotional”	

**SLEEP/ENERGY**  
How a Person Experiences Their Energy Level and/or Sleep Patterns

Fatigue	Drowsiness
Excess sleep Trouble	Sleeping less than usual
falling asleep	

Do not worry that your child has symptoms for 1 to 4 weeks; it is typical and natural to notice symptoms for 1 to 4 weeks. You just want to make sure you are seeing slow and steady resolution of symptoms every day. To monitor your child’s progress with symptoms, chart symptoms periodically (see TIMEFRAME on page 5) and use the Symptom Checklist (see APPENDIX). In a small percentage of cases, symptoms from a concussion can last from weeks to months. (See SPECIAL CONSIDERATIONS on page 13.)

**Medical Note from Danny G. Thomas MD, MPH**

Studies have shown there is no benefit in excessive rest. In fact excessive rest has been associated with worse symptoms and longer recovery. Because of the social and emotional importance of school, it is beneficial to help students gradually return to their normal routine. The general advice to guide activity in the first week is “push to, not through, symptoms.” Tolerating more and more academic and physical activity without worsening symptoms are signs of a healthy recovery.

**IMPORTANT**

All symptoms of concussion are important; however, monitoring of physical symptoms, within the first 48 to 72 hours is critical! If physical symptoms worsen, especially headache, confusion, disorientation, vomiting, difficulty awakening, it may be a sign that a more serious medical condition is developing in the brain.

**SEEK IMMEDIATE MEDICAL ATTENTION!**

# + Energy Management

Pages 4 & 5

- iPhone 4, not iPhone X



- Car with small gas tank



**C  
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### Family Team

#### **REDUCE**

**Limit** (don't eliminate) texting.

**Limit** TV, video games, computer time.

**Limit** homework.

Keep home from dances, games, the mall. Decrease stimulation.

**REST!**

### School Academic Team

Keep home if severely symptomatic (usually 2-4 days)

Return to school when symptoms are present but tolerable, intermittent and amenable to rest.

**Limit** (don't eliminate) school work, **REMOVE** non-essential work, **REDUCE** semi-essential work

**PACE  
MENTAL  
DEMANDS**

Day 1/Week 1

Week 2

Week 3

Week 4

# RETURNING TO SCHOOL

## No such thing as “medical clearance” for school

**AFTER YOUR CHILD HAS RECEIVED THE DIAGNOSIS OF CONCUSSION** by a healthcare professional, their symptoms will determine when they should return to school. As the parent, you will likely be the one to decide when your child goes back to school because you are the one who sees your child every morning before school. Use the chart below to help decide when it is right to send your child back to school:

### STAY HOME – BED REST

If your child’s symptoms are so severe that he/she cannot concentrate for even 10 minutes, he/she should be kept home on total bed rest - no texting, no driving, no reading, no video games, no homework, limited TV. It is unusual for this state to last beyond a few days. Consult a physician if this state lasts more than 2 days.

**MAXIMUM REST = MAXIMUM RECOVERY**

### STAY HOME – LIGHT ACTIVITY

If your child’s symptoms are improving but he/she can still only concentrate for up to 20 minutes, he/she should be kept home — but may not need total bed rest. Your child can start light mental activity (e.g. sitting up, watching TV, light reading), as long as symptoms do not worsen. If they do, cut back the activity and build in more REST.

**NO physical activity allowed!**

## TRANSITION BACK TO SCHOOL

When your child is beginning to tolerate 30 to 45 minutes of light mental activity, you can consider returning them to school. **As they return to school:**

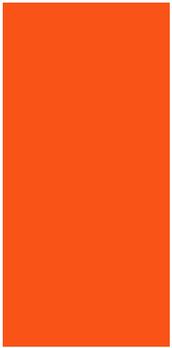
- Parents should communicate with the school (school nurse, teacher, school mental health and/or counselor) when bringing the student into school for the first time after the concussion.
- Parents and the school should decide together the level of academic adjustment needed at school depending upon:

- ✓ The severity of symptoms present
- ✓ The type of symptoms present
- ✓ The times of day when the student feels better or worse

- When returning to school, the child **MUST** sit out of physical activity – gym/PE classes, highly physically active classes (dance, weight training, athletic training) and physically active recess until medically cleared.
- Consider removing child from band or music if symptoms are provoked by sound.



# Return to School vs. Return to Learn



## RTS

**Return to School** is defined as the process of the student physically walking back into a school setting. The decision to send a child to school on any given day is directed by the parent and is dependent upon the student's ability to manage symptoms well enough to be physically and cognitively present in the classroom to listen and learn

## RTL

**Return to Learn** is defined as the process by which educators help students with concussion maximize learning while minimizing symptom flare-ups. A successful Return to Learn plan is directed by educators, especially general education teachers, who have knowledge and skill in differentiated instruction to meet the needs of all students regardless of medical, psychological, learning, behavioral or social conditions

STEP THREE: ADJUST/  
ACCOMMODATE for EDUCATORS.



School Team Educators

Return to Learn (RTL)

RTL refers to a teacher's ability to help a student with a concussion learn to "pace" levels of energy in order to maximize learning while minimally contributing to symptom flare-ups. A RTL plan is most robust when teachers, especially general education teachers, are empowered to make educational decisions for their students hourly, daily and weekly, as they see fit. While medical input may be helpful in an RTL plan, teachers need not wait for medical input/"clearance"/approval to apply or remove academic adjustments, especially if medical input is not forthcoming, timely, available or relevant. RTL recommendations provided by healthcare providers are "suggestions," not mandates. Schools may accept or reject outside RTL suggestions based upon its educational soundness, feasibility and alignment with school policy/protocol.

# » Most Common "Thinking" Cognitive Problems Post-Concussion

## And suggested adjustments/accommodations

Areas of concern	Suggested Accommodations for Return-to-Learn (RTL)
Fatigue, specifically Mental Fatigue	<ul style="list-style-type: none"> <li>Schedule "strategic" rest periods. Do not wait until the student's over-tiredness results in an emotional "meltdown." Proactively adjust the schedule to incorporate a 15-20 minute rest period 1X mid-morning and 1X mid-afternoon, as needed.</li> <li>Allow for "PACING" – 5 to 10 minute eye/brain/water breaks in the classroom after periods of mental exertion.</li> <li>Do not consider "quiet reading" as rest for all students.</li> <li>Consider letting the student have sunglasses, headphones, preferential seating, quiet work space, passing in quiet halls, etc., as needed.</li> </ul>
Difficulty concentrating	<ul style="list-style-type: none"> <li>REDUCE the cognitive load—it is a fact that smaller amounts of learning will take place during the recovery.</li> <li>Since learning during recovery is compromised, the academic team must decide: What is the most important concept for the student to learn during this recovery?</li> <li>Be careful not to tax the student cognitively by demanding that all learning continue at the rate prior to the concussion.</li> </ul>
Slowed processing speed	<ul style="list-style-type: none"> <li>Provide extra time for tests and projects and/or shorten tasks.</li> <li>Assess whether the student has large tests or projects due during the 4-week recovery period and remove or adjust due dates.</li> <li>Provide a peer notetaker or copies of teacher's notes during recovery.</li> <li>Grade work completed—do not penalize for work not done.</li> </ul>
Difficulty with working memory	<ul style="list-style-type: none"> <li>Initially exempt the student from routine work/tests.</li> <li>Since memory during recovery is limited, the academic team must decide: What are the most important concepts for the student to know?</li> <li>Work toward comprehension of a smaller amount of material versus rote memorization.</li> </ul>
Difficulty converting new learning into memory	<ul style="list-style-type: none"> <li>Allow student to "audit" the material during this time.</li> <li>REMOVE "busy" work that is not essential for comprehension. Making the student accountable for all of the work missed during the recovery period (4 weeks) places undue cognitive and emotional strain on him/her and may hamper recovery.</li> <li>Ease student back into full academic/cognitive load.</li> </ul>
Emotional symptoms	<ul style="list-style-type: none"> <li>Be mindful of emotional symptoms throughout! Students are often scared, overloaded, frustrated, irritable, angry and depressed as a result of concussion. They respond well to support and reassurance that what they are feeling is often the typical course of recovery.</li> <li>Watch for secondary symptoms of depression – usually from social isolation. Watch for secondary symptoms of anxiety – usually from concerns over make-up work or slipping grades.</li> <li>New research informs us of the impact a concussion can have on emotional well-being. Supportive psychological support, education, cognitive-behavioral strategies and stress reduction are all suggested for psychological rehabilitation.</li> </ul>

# When can I go back to my sport?

## » Is the student/athlete 100% symptom-free at home?

- Use the Symptom Checklist every few days. All symptoms should be at "0" on the checklist or at least back to the perceived "baseline" symptom level.
- Look at what the student/athlete is doing. At home he/she should be acting the same way as before the concussion, doing chores, interacting normally with friends and family.
- Symptoms should not return when the student/athlete is exposed to the loud, busy environment of home/social, mall or restaurants.

## » Is the student 100% symptom-free at school?

- Your student/athlete should be handling school work at the same level as before the concussion.
- Use the Teacher Feedback Form (APPENDIX) to see what teachers are noticing.
- Watch your child/teen doing homework; he/she should be able to complete homework as efficiently as before the concussion.
- In-school test scores should be back to where they were pre-concussion.
- School workload should be back to where it was pre-concussion.
- Symptoms should not return when the student/athlete is exposed to the loud, busy environment of school.

## » If the school or healthcare professional has used neurocognitive testing, are scores back to baseline or at least reflect normative average and/or baseline functioning?

## » If an athletic trainer (AT) or physical therapist (PT) is involved with the concussion, does the AT or PT feel that the student/athlete has reached his/her objective goals?

- Ask AT for feedback and/or serial administrations of the Symptom Checklist.

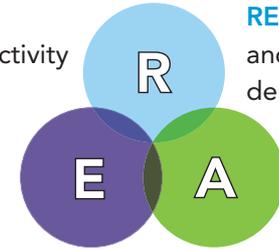
## » Is the student off all medications used to treat the concussion?

- This includes over-the-counter medications such as ibuprofen, naproxen and acetaminophen, which may have been used to treat headache or pain.

If the answer to any of the questions is "NO," stay the course with management and continue to repeat:

**REMOVE**

physical activity



**REDUCE** home and cognitive demands

**ADJUST/ ACCOMMODATE**

home/social and school activities

**EDUCATE:** Let the symptoms direct the interventions

... for however long it takes for the brain cells to heal!

Once the answers to the questions above are all "YES," turn the page to the PACE page to see what to do next!



# Symptom Checklist

Name: \_\_\_\_\_ Assessment Date: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Time of Injury 2-3 Hrs 24 Hrs 48 Hrs 72 Hrs Daily Weekly

SYMPTOMS		SEVERITY RATING						
Pathways	Symptoms	Mild	Mild	Moderate	Moderate	Severe	Severe	
A	I feel like I'm going to faint	0	1	2	3	4	5	6
V	I'm having trouble balancing	0	1	2	3	4	5	6
	I feel dizzy	0	1	2	3	4	5	6
	It feels like the room is spinning	0	1	2	3	4	5	6
O	Things look blurry	0	1	2	3	4	5	6
	I see double	0	1	2	3	4	5	6
H	I have headaches	0	1	2	3	4	5	6
	I feel sick to my stomach (nauseated)	0	1	2	3	4	5	6
	Noise/sound bothers me	0	1	2	3	4	5	6
	The light bothers my eyes	0	1	2	3	4	5	6
C	I have pressure in my head	0	1	2	3	4	5	6
	I feel numbness and tingling	0	1	2	3	4	5	6
N	I have neck pain	0	1	2	3	4	5	6
S/E	I have trouble falling asleep	0	1	2	3	4	5	6
	I feel like sleeping too much	0	1	2	3	4	5	6
	I feel like I am not getting enough sleep	0	1	2	3	4	5	6
	I have low energy (fatigue)	0	1	2	3	4	5	6
	I feel tired a lot (drowsiness)	0	1	2	3	4	5	6
Cog	I have trouble paying attention	0	1	2	3	4	5	6
	I am easily distracted	0	1	2	3	4	5	6
	I have trouble concentrating	0	1	2	3	4	5	6
	I have trouble remembering things	0	1	2	3	4	5	6
	I have trouble following directions	0	1	2	3	4	5	6
	I feel like my thinking is "foggy"	0	1	2	3	4	5	6
	I feel like I am moving at a slower speed	0	1	2	3	4	5	6
	I don't feel "right"	0	1	2	3	4	5	6
	I feel confused	0	1	2	3	4	5	6
	I have trouble learning new things	0	1	2	3	4	5	6
E	I feel more emotional	0	1	2	3	4	5	6
	I feel sad	0	1	2	3	4	5	6
	I feel nervous	0	1	2	3	4	5	6
	I feel irritable or grouchy	0	1	2	3	4	5	6

Other: \_\_\_\_\_ All rights reserved: © GetSchooledOnConcussions.com

# Teacher Feedback Form

Date \_\_\_\_\_

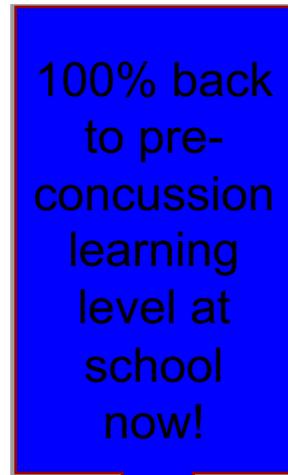
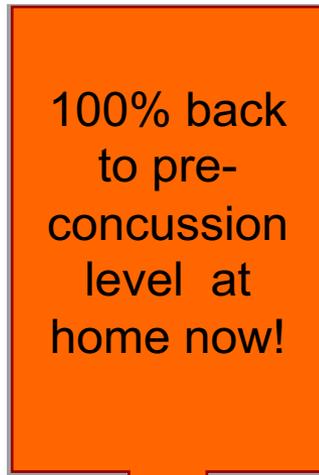
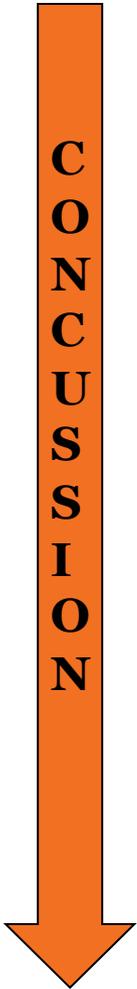
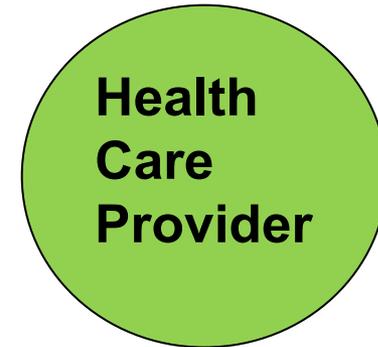
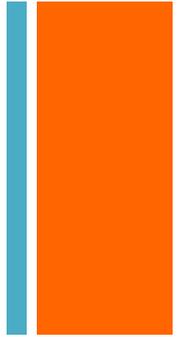
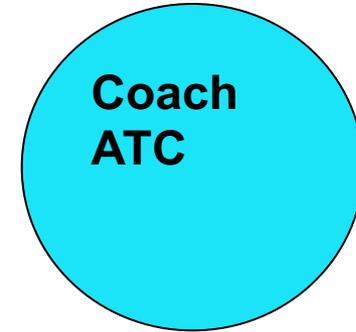
>> Student's Name \_\_\_\_\_

Date of Concussion \_\_\_\_\_

**Student:** you have been diagnosed with a concussion. It is your responsibility to gather data from your teachers before you return to the doctor for a follow-up visit. A day or two before your next appointment, go around to all of your teachers (especially the CORE classes) and ask them to fill in the boxes below based upon how you are currently functioning in their class(es).

**Teachers:** Thank you for your help with this student. Your feedback is very valuable. We do not want to release this student back to physical activity if you are still seeing physical, cognitive, and emotional or sleep/energy symptoms in your classroom(s). If you have any concerns, please state them below.

1. Your name 2. Class taught	Is the student still receiving any academic adjustments in your class? If so, what?	Have you noticed, or has the student reported, any concussion symptoms lately? (e.g. complaints of headaches, dizziness, difficulty concentrating, remembering; more irritable, fatigued than usual etc.?) If yes, please explain.	Do you believe this student is performing at their pre-concussion learning level?
			<input type="checkbox"/> Yes <input type="checkbox"/> No Date: Signature:
			<input type="checkbox"/> Yes <input type="checkbox"/> No Date: Signature:
			<input type="checkbox"/> Yes <input type="checkbox"/> No Date: Signature:
All rights reserved: © GetSchooledOnConcussions.com			<input type="checkbox"/> Yes <input type="checkbox"/> No Date: Signature:



## APPROVED to START the GRTP steps

NOT CLEARED until successfully completed the steps

S

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

NOTE: An initial period of 24 – 48 hours of both relative physical rest and cognitive rest is recommended before beginning the RTS progression. There should be at least 24 hours (or longer) for each step of the progression. If any symptoms worsen during exercise, the athlete should go back to the previous step. Resistance training should be added only in the later stages (stage 3 or 4 at the earliest). If symptoms are persistent (e.g. more than 10 – 14 days in adults or more than 1 month in children), the athlete should be referred to a healthcare professional who is an expert in the management of concussion.

International Consensus Statements have outlined this as a safe practice for professional athletes when returning to an organized sport; these steps might ideally also be applied as best practice when returning any person with a concussion back to a recreational sport/activity.

### Rehabilitation Note

The 5th Consensus Statement suggests: After a brief period of rest during the acute phase (24-48 hours) after injury, patients can be encouraged to become gradually and progressively more active while staying below their cognitive and physical symptom-exacerbation thresholds (i.e., activity level should not bring on or worsen their symptoms). It is reasonable for athletes to avoid vigorous exertion while they are recovering. The exact amount and duration of rest is not yet well defined in the literature and requires further study.<sup>3</sup>

## Nebraska Concussion Awareness Act:

On July 1, 2012, the Concussion Awareness Act became law. All public, private, and parochial schools, as well as all organized youth sports sponsored by villages, cities, businesses, or non-profit organizations for children ages 19 and under, are required to make concussion training available to coaches. Under the law, an athlete showing signs or symptoms of a concussion, thereby being "reasonably suspected" of having had a concussion, must be removed from participation and may not return until evaluated by a licensed health care professional. The law includes three requirements:

1. Education: All coaches, youth athletes, and their parent or guardian must be provided with education about the risks and symptoms of concussion and how to seek proper medical attention.
2. Removal from Play: Under any reasonable suspicion of concussion, coaches will remove youth athletes from play.
3. Return to Play: Youth athletes will not be allowed to return to play including games, scrimmages, and practices of any kind, until written approval from an appropriate licensed healthcare professional AND the youth's parent or guardian is obtained.
4. PLUS a 2014 Amendment included a protocol which requires accredited schools to establish a Return to Learn Protocol for students that have sustained a concussion.

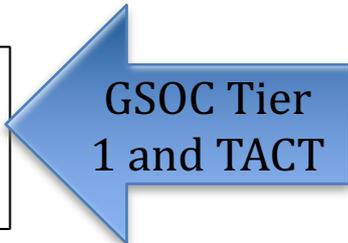
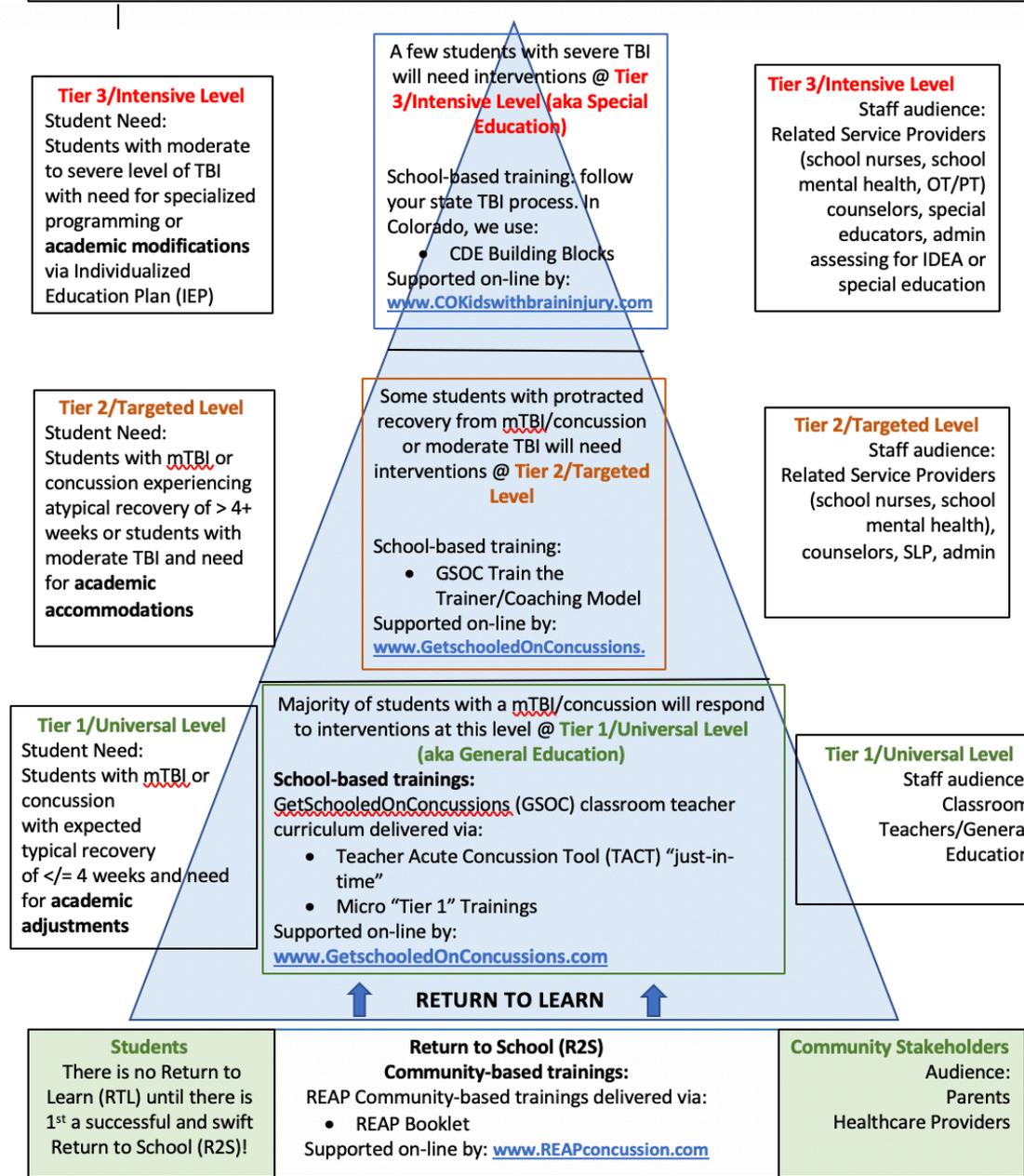
The entire bill is available at the website:

<http://www.nebsportsconcussion.org/images/pdfs/lb260-final.pdf>

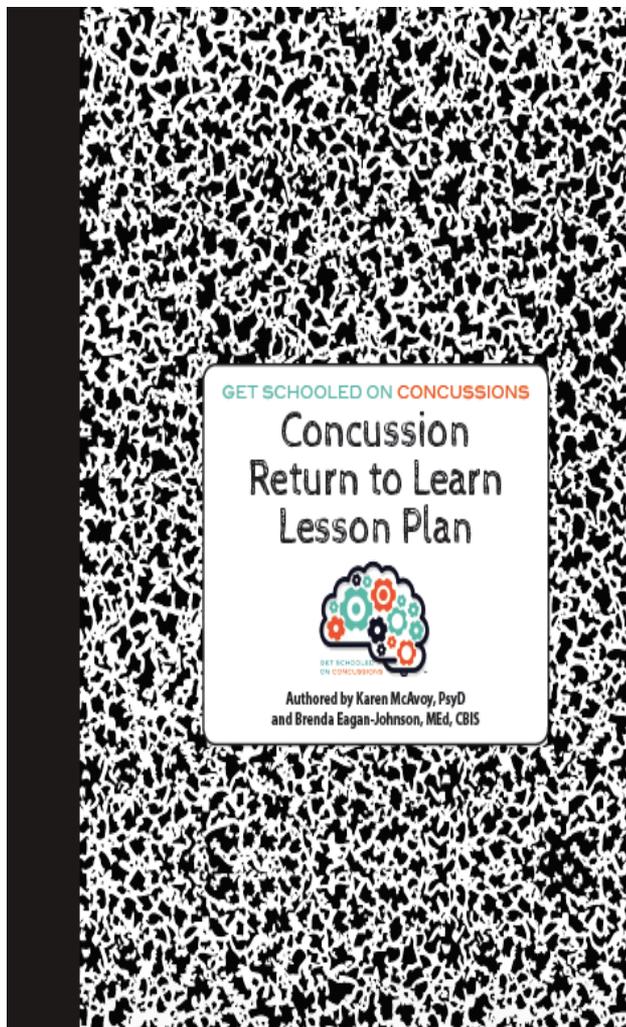
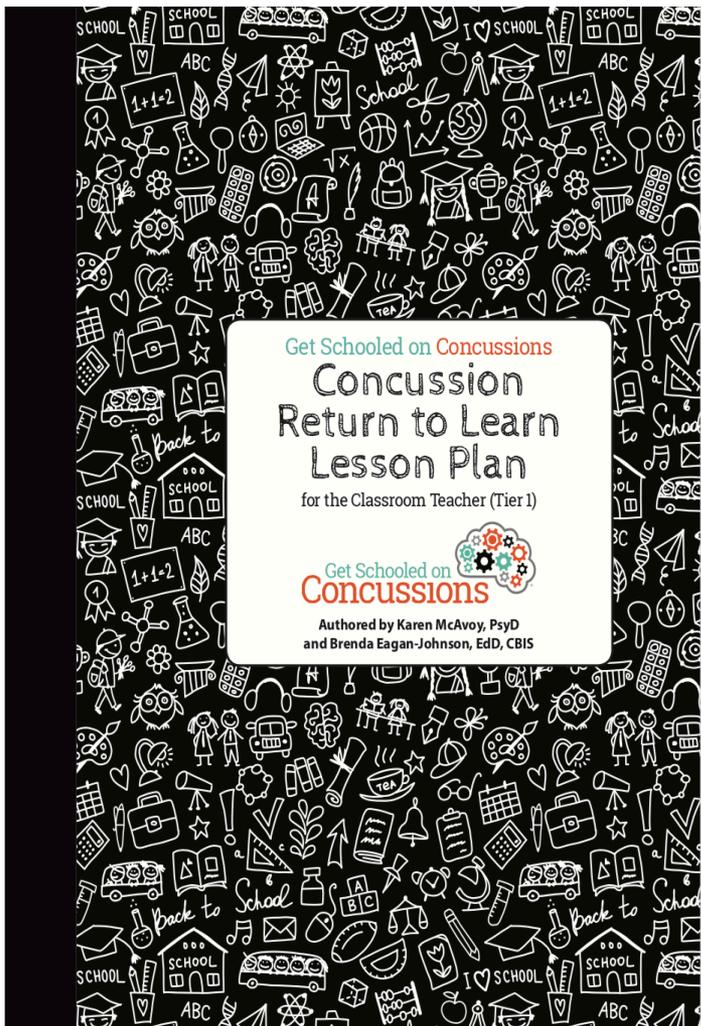


[GetSchooledOnConcussions.com](http://GetSchooledOnConcussions.com)

Return to Learn: A Schooled-Based and School-Directed RTL Protocol



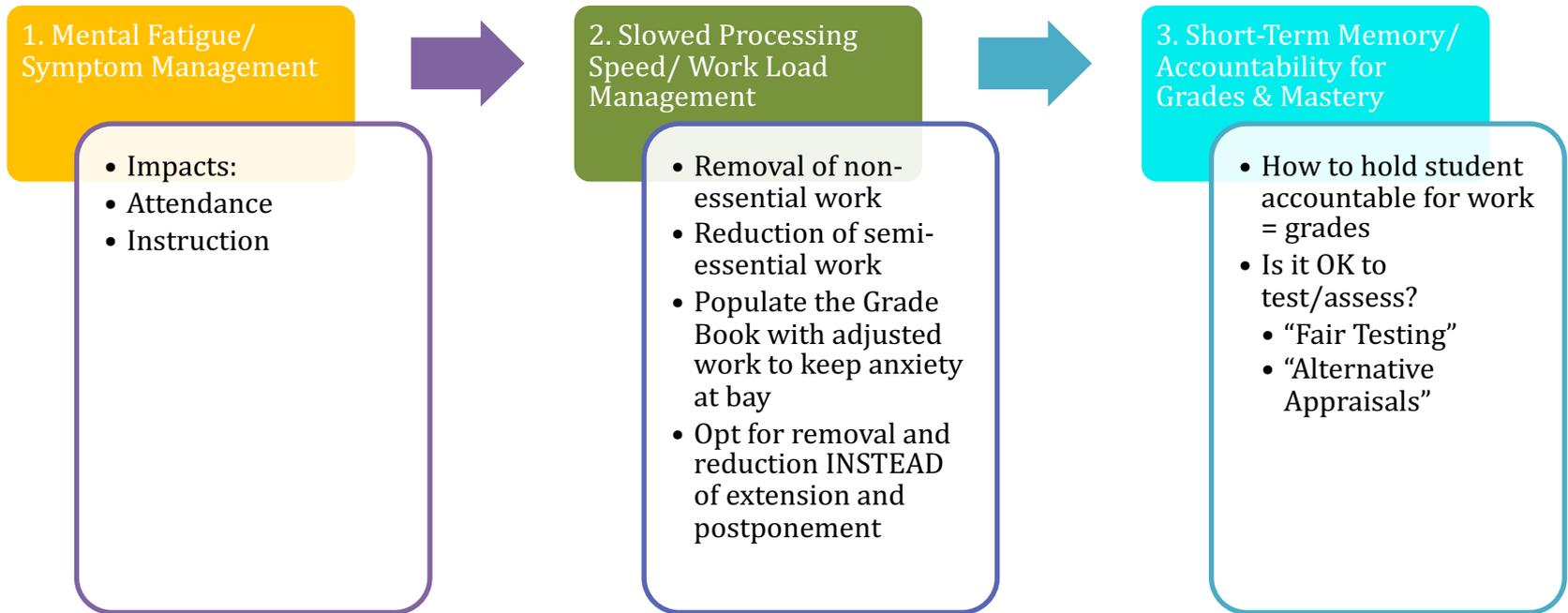
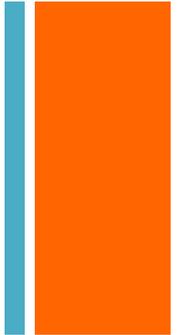
GSOC Tier 1 and TACT



- ✓ What to do in the classroom?
- ✓ What to do about missed instruction?
- ✓ What to do about make-up work?
- ✓ What to do about quizzes/test?
- ✓ What to do about extracurricular activities?



# 3 Common Effects of Concussion... and their impact in the classroom





# 1. Mental Fatigue: Symptom Management = Energy Management



Impacts:

- Attendance
- Instruction



Poor or partial attendance



Lack of exposure to  
classroom instruction

Difficulty for classroom  
teacher to give the “gift” of  
adjusted work load

# 1. Mental Fatigue: Symptom Management = Energy Management

## Rest Breaks:

- “Pacing” – eyes closed/ head down/ water breaks for 5 to 10 minutes, IN the classroom, after periods of mental exertion
  - Take eyes off the book/computer and look away
  - Take more water breaks – and more frequent bathroom breaks
  - Take a 5 minute “bean bag” or “head on desk” rest break in the classroom as needed
- “Strategic Rest Breaks” – 15 to 20 minute “proactive” rest break in the school clinic 1X mid-am and 1x mid- pm as needed



## 2. Slowed Processing Speed/ Work Load Management

Once a student with a concussion has been in class to hear instruction, the teacher can begin to focus on *differentiated instruction*:

- Removal of non-essential work
- Reduction of semi-essential work
- Clear expectations on essential work, prioritizing current work over make-up work

Extensions and postponement of work tend to heighten anxiety, especially if the concussion goes on for 3+ weeks. **A reasonable work load is necessary!**

## + 2. Slowed Processing Speed/ Work Load Management

Other differentiated instruction for work load management:

- Focus on comprehension, not memorization
- Focus on quality, not quantity
- Allow for more group work
- Allow for academic supplements such as:
  - Audio books
  - Teacher notes/Buddy notes
  - Colored paper/Tinted overlays
  - Ear buds for noise/passing in halls alone for balance/sunglasses for light

# 3. Short-Term Memory

## Accountability for Grades and Mastery

Once a student with a concussion has been in class to hear instruction, and has been demonstrating learning with a reduced, reasonable work load, then a teacher can begin to focus on “How do I test/assess my student’s mastery and give a grade? Consider:

- “Alternative Appraisals” – Can I assess level of mastery in a creative, alternative fashion? (oral presentation, collage, video)
- “Fair Testing” – Was the student physically and cognitively present to learn the material and can retain the material?



# 3. Short-Term Memory Accountability for Grades and Mastery

## Alternative Appraisals

- Oral presentations
- Video presentations
- Collages
- Group work

## Fair Testing

If a test/final is necessary:

- Open book
- Multiple choice
- Extended time
- No more than 1 test per day

These strategies are all within the purview of the teacher and do not require medical approval. Consider forgoing testing in the first 1 to 2 weeks post-concussion. However, consider attempting some (adapted) assessments as recovery progresses into week 3 and 4 and beyond.

# + Medical Clearance for “Thinking?”

Clearance for returning to  
“Cognitive Activity”  
NOT part of the  
concussion in youth sports laws.

You do NOT need a medical clearance for  
a student to return to school following a  
concussion.





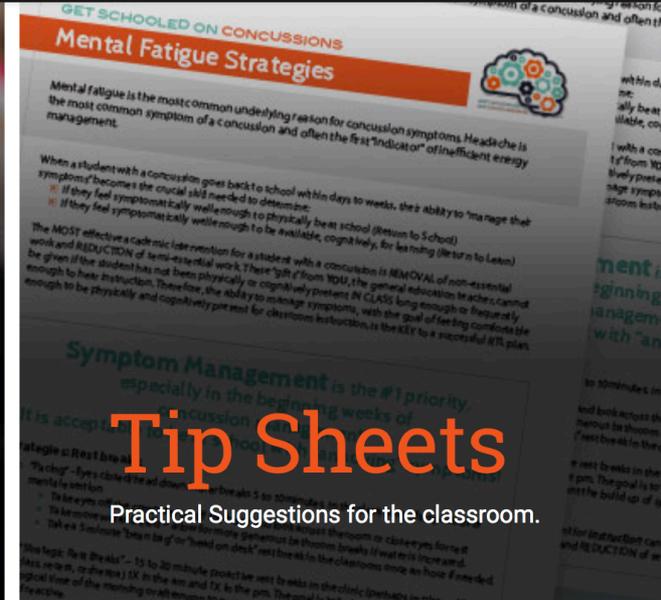
# Teacher Acute Concussion Tool (TACT)



# TACT

## (Teacher Acute Concussion Tool)

Engage in an interactive web-based questionnaire to find out how your teaching style, content area, environmental and student factors lead to specific classroom strategies for the student with a concussion in your classroom.



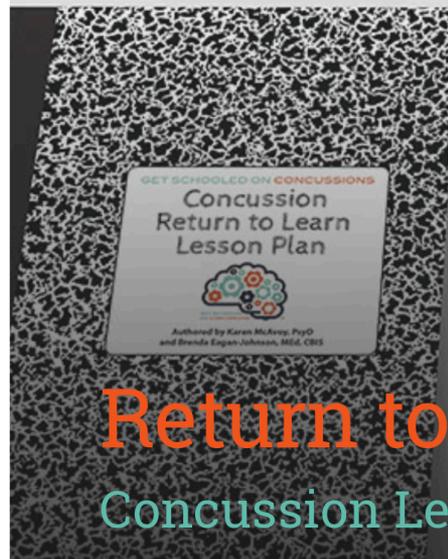
# Tip Sheets

Practical Suggestions for the classroom.



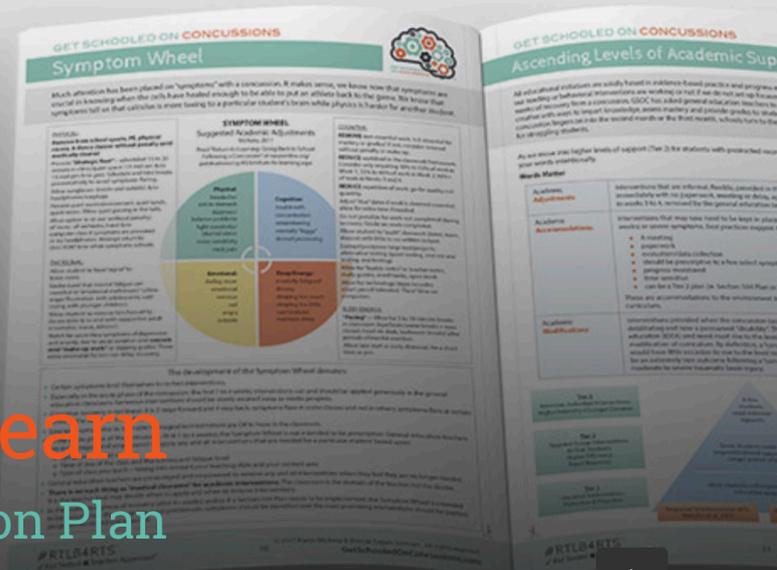
# Trainings

Hands-on trainings for teachers, school nurses, counselors, school psychologists, social workers and administrators.



# Return to Learn Concussion Lesson Plan

✓ Kid Tested ● Teacher Approved™ curriculum for in the general classroom ... and beyond.



**I teach \***

- at the Elementary level
- at the Middle or High School level

## Middle or High School level

**You have been informed of a student with a concussion in your class. Please mark if you have that student in your morning class(es), afternoon classes(es) or both morning and afternoon classes. \***

- In the morning
- In the afternoon
- I have this student in both morning and afternoon classes

**Please rate the time of the grading period this concussion is coming to your attention (1 = very beginning of the grading period; 3 = middle of the grading period; 5 = end of the grading period): \***

1	2	3	4	5
<input type="radio"/>				

**Please mark which style of teaching (simultaneous versus sequential) best describes the way you deliver instruction: \***

- In general, I teach in a way where new general concepts layer over past concepts. Learning builds over weeks to months. Or I teach a topic where concepts don't necessarily layer over past concepts at all. Examples: Social Studies, Language Arts, Health.
- My content area is primarily sequential: I teach concepts where each new lesson builds on the last 1 to 2 lessons. Yesterday's learning is important for today's learning (i.e. Math, Science).
- Some of my content builds on past learning from yesterday; some of my content builds on general concepts from weeks to months ago.

Mental Fatigue	Slowed Processing Speed	Short-Term Memory
Symptom (aka) Energy Management <ul style="list-style-type: none"> <li>• Impacts attendance</li> <li>• Impacts instruction</li> </ul>	Impacts work output <ul style="list-style-type: none"> <li>• REMOVE non-essential work</li> <li>• REDUCE semi-essential work</li> </ul>	Impacts demonstration of mastery, tests & grades <ul style="list-style-type: none"> <li>• “Fair Testing”</li> <li>• “Alternative Appraisals”</li> </ul>

You selected: I have this student in both morning and afternoon classes

- A concussion is an **energy crisis** (brain running on empty) that leads to **mental fatigue** which leads to symptoms of headaches, dizziness, tiredness, difficulty concentrating, irritability, etc. Flaring of symptoms is the biggest contributor to truancy, missed instruction from the classroom (due to being in the school clinic) and/or inability to learn due to pain. Your **1st goal** in supporting a student with a concussion back into your classroom is to help your student manage symptoms so they can be physically and cognitively present in class, all day, every day, so they can hear instruction.

**Mental Fatigue** Strategies:

- "Pace" their energy - allow frequent 5 to 10 minute eye/brain/water/bathroom breaks **IN** the classroom after periods of mental exertion and/or
- "Strategic Rest Breaks" - a proactive 20 minute rest break in the school clinic 1X mid-morning and/or 1X mid-afternoon

If you teach this student in both morning and afternoon classes, encourage your student to pace energy so they can stay at school all day, if possible. **Being able to attend school and hear instruction is a necessary 1st step before adjustment of workload can happen.**

- Attachment(s):
  - [Mental Fatigue Strategies](#)

## Technology:

- It is common for electronic and visual technology to be taxing to students with a concussion due to focused eye demands. When you are teaching a lesson where technology is needed, watch out for **Mental Fatigue** which may lead to flaring of symptoms. The common medical advice of NO computers, NO screens is not a reasonable or practical academic suggestion. Instead, allow for measured/limited time on technology while keeping symptoms at bay with **Mental Fatigue** Strategies:
  - “Pacing”
  - “Strategic Rest Breaks”
  - Adjust font size, style and background lighting

Lighten work output expectations (**Slowed Processing Speed** Strategies) and be creative with assessing mastery and giving grades (**Short-Term Memory** Strategies).

## Reading:

- It is common for reading to be taxing to students with a concussion due to focused eye demands. When you are teaching a lesson where reading is needed, watch out for **Mental Fatigue** which may lead to flaring of symptoms. The common medical advice of NO reading during a concussion is not a reasonable or practical academic suggestion. Instead, allow for measured/limited time reading while keeping symptoms at bay with **Mental Fatigue** Strategies. Allow for:
  - “Pacing”
  - “Strategic Rest Breaks”
  - Audio books
  - Larger font
  - Tinted overlays
  - Colored paper (subtle colors)
  - Tracking/Frame guide

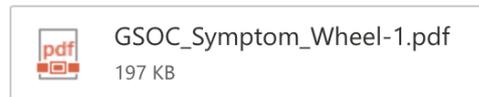
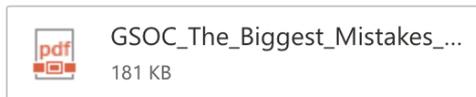
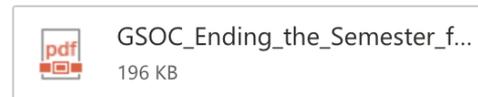
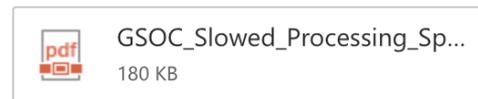
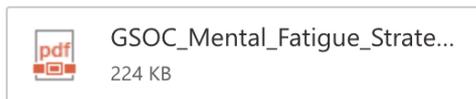
Lighten work output expectations (**Slowed Processing Speed** Strategies) and be creative with assessing mastery and giving grades (**Short-Term Memory** Strategies).



TACT Team <tact@getschooledonconcussions.com>

Mon 9/9/2019 3:26 PM

TACT ∨



## GET SCHOOLED ON CONCUSSIONS

# Fading Academic Adjustments



### Week 1

Maximize academic adjustments  
Remove non-essential work  
Reduce semi-essential work

"Pacing" – Give FREQUENT eye/brain/water breaks - 5 to 10 minute breaks in the classroom after focusing for 20 to 30 minutes on reading or computer

"Strategic Rest Breaks" – Allow a mid-morning and a mid-afternoon break (20 minutes each) in clinic at pre-determined times to keep symptoms at bay

Keep symptoms low and tolerable

Focus on just keeping the student feeling well enough to be in class - listening & learning. Focus less on work output at this point.

### Week 2

Begin to "dip toe" in water; slowly try more work  
Continue to remove majority of non-essential work

Continue to reduce majority of semi-essential work – Do not let make-up work pile up

Consider extending timeframes for essential work

Continue to allow eye/brain breaks in class, but begin to space those out when/if not needed

Wear back "strategic rest break" visits to clinic

Keep symptoms improving

Continue to prioritize comprehension and learning over work output

Continue to prioritize current work over make-up work

### Weeks 3 and 4

Continue to adjust academic expectations

Continue to remove and reduce some work but continue to add in more work as healing and time progress

Continue to fade rest breaks

Continue to focus on comprehension

Continue to focus on current work rather than make-up work

It is not possible to keep up with current work and also make-up missed work – prioritize what make-up work is most important and make sure it is a reasonable amount

Continue to assure that symptoms are resolving

Seventy percent of concussions will resolve in 4 weeks with just good management.

Once a student with a concussion comes to your attention, **FRONTLOAD** your academic adjustments (view Symptom Wheel) during week 1 and week 2.

Be as generous as you can be in the beginning of a concussion. As week 1 progresses to week 4, the concussion should slowly resolve. Fade your academic supports away slowly over 1 to 4 weeks.

If the student does not show steady resolution of symptoms and/or if the student is not able to tolerate more academic expectations by week 4, talk to your Concussion Management Team Point Person, or school nurse/counselor/administrator.

#RTLBARTS  
✓ Kid Tested • Teacher Approved

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## GET SCHOOLED ON CONCUSSIONS

# Concussion Return to Learn Lesson Plan



Authored by Karen McAvoy, PsyD  
and Brenda Eagan-Johnson, MEd, CBIS

## Is there an appropriate time to initiate a more formal plan and/or a 504 plan?

30%?

Ask yourself:

Have you maximized your immediate, flexible, fluid and generous academic adjustments from Day 1 to Week 4?

Student is not yet recovered?

Student needs more time?

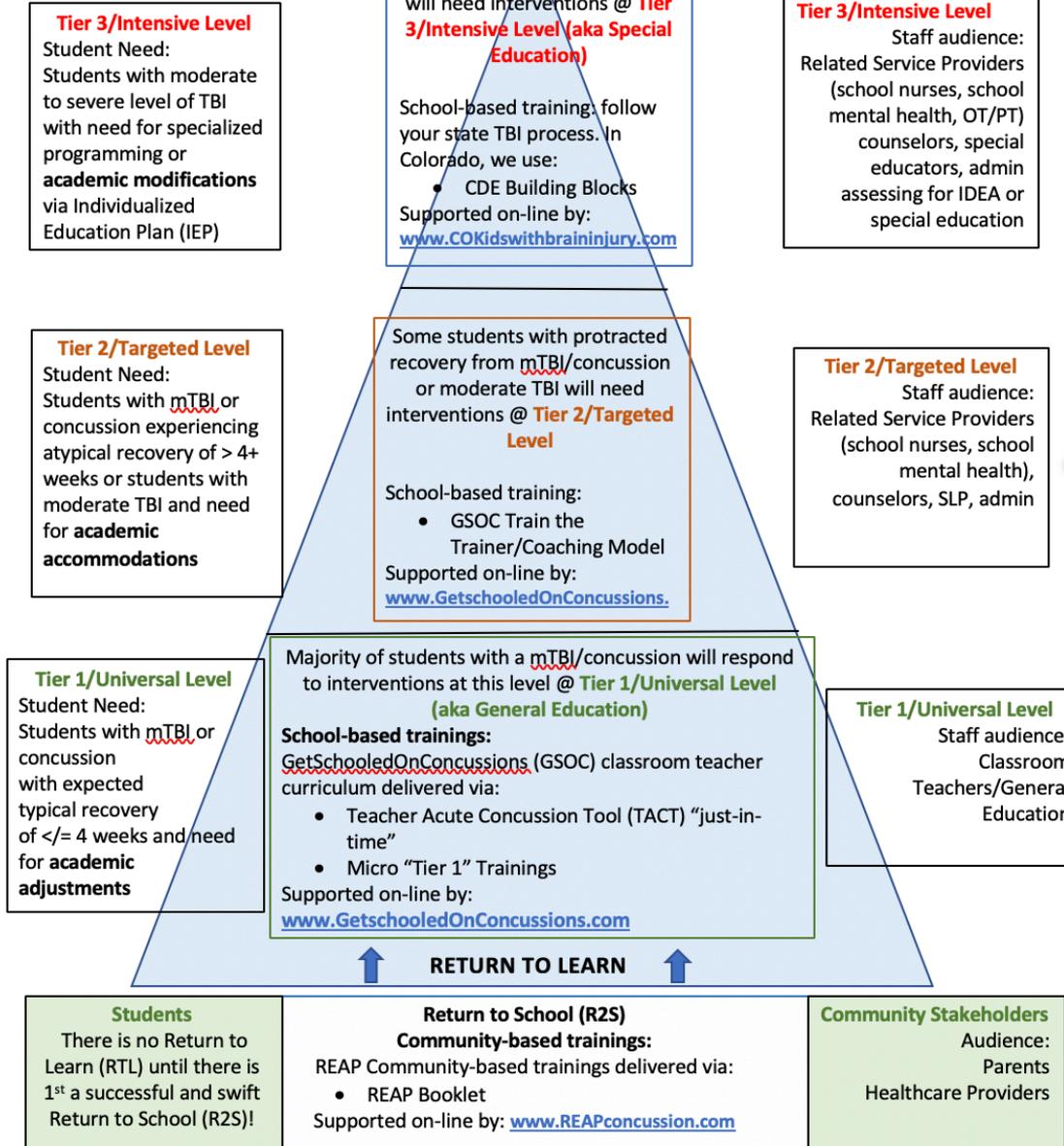
Perhaps due to:

- History/Family Hx of headaches/migraines
- History of past concussions
- Learning issues; Attentional issues
- Underlying psychological issues (anxiety, depression, school avoidance/phobia)
- Multiple past concussions
- Oculomotor issues/Convergence Insufficiency
- Vestibular issues
- Dysautonomia
- Poor management?

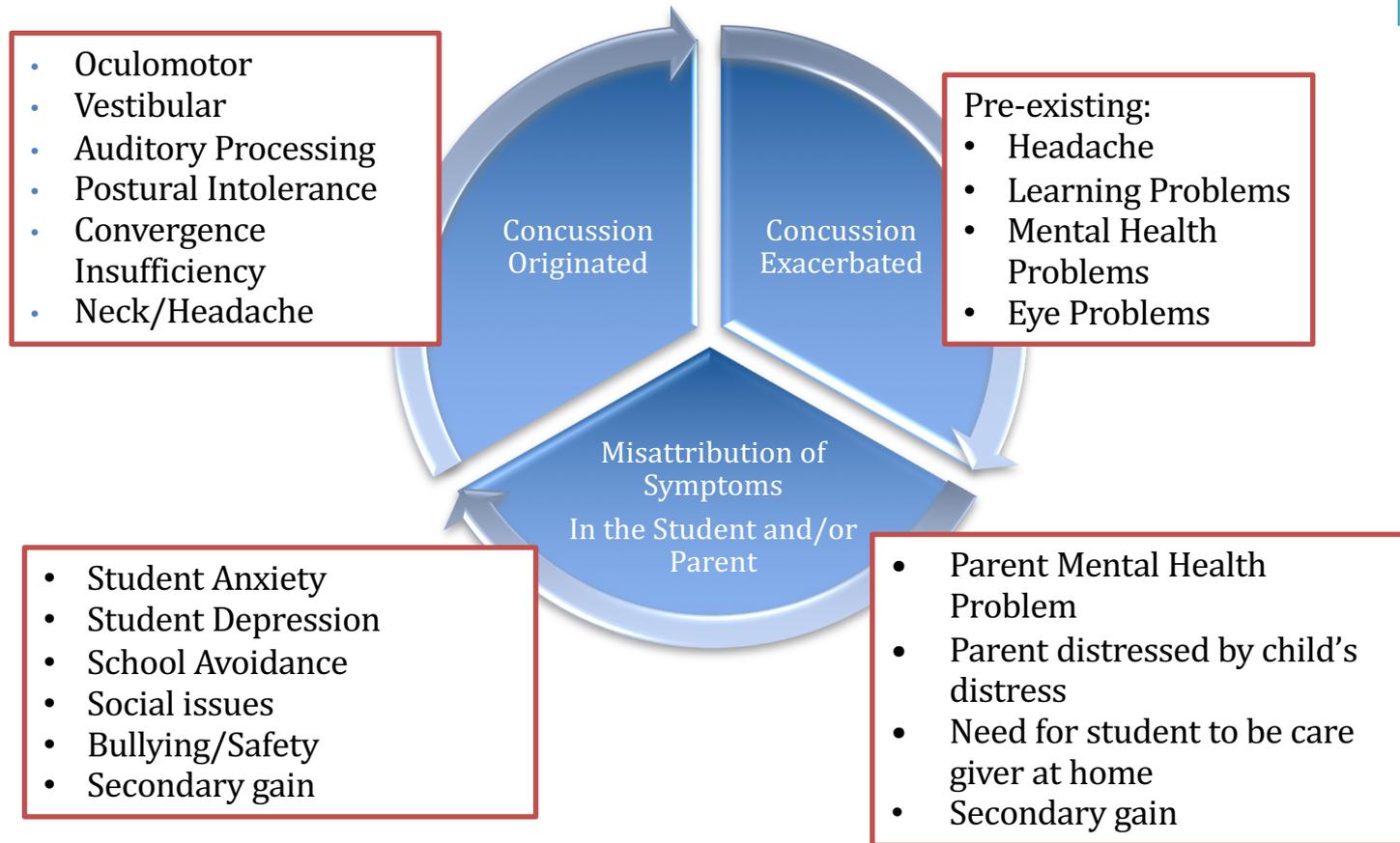
Is may be time to offer **academic accommodations?**

***Maybe!***

Return to Learn: A Schooled-Based and School-Directed RTL Protocol



# + Possible contributors to protracted recovery from concussion





# Rehabilitation

## Oculomotor/Convergence Insufficiency – eyes

- Limited computer screens/reading
- Large print
- Teacher/buddy notes
- Tinted overlays
- Preferential seating
- Audio books
- Corrective lenses

## Mood/Behavior – emotions & behaviors

- Extra TLC
- Clear expectations about work
- Check in/Check out
- Emotion Regulation
- Coping Mechanisms/Cog-Beh Tools

## Cervical Strain – increases headaches

- Second set of books
- Extra time for locker
- Head on desk

## Vestibular – ears/balance Auditory Processing

- Preferential seating
- Passing in halls early or late
- Extra time for locker
- Elevator key
- Headphones/ear buds

## Postural Dizziness

- Increased water at school
- Frequent Water breaks
- Bathroom breaks
- Elevator key
- Slowly moving from sitting to standing

## Focus at Phases of Recovery



Week 1 through 4

ACUTE

SYMPTOM

MANAGEMENT **MF**

- “Pacing”
- “Strategic rest breaks”

ATTENDANCE is key!

REMOVAL of non-essential

REDUCTION of semi-essential - extension or postponement NOT adequate **PS**

Adjustment of essential work (extension or postponement is OK in small amounts) **STM**

Week 5 through 9

REHAB MODEL

Balance of make-up and current work with reasonable

REMOVE/REDUCE plan.

Reasonable plan for essential work (limit extension or postponement) **PS/STM**

Physical Therapy/Light Cardio Rehab

Symptoms should be managed (by student or medically) – No/Few absences from school **MF**

Week 10+  
PROTRACTED

Normalization of life

**Rehab Plan:**  
originated/exacerbated/  
misattribution

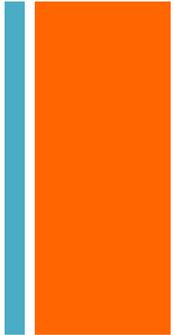
Focus on current work  
Stable, forward focused  
academic plan (no make-up work and no postponements) **PS/STM**

Symptoms should be managed - No absences from school **MF**



# Section 504 Decision Formula for Concussion

*Length of Time AND/OR Severity of Symptoms PLUS Need {L &/or S + N}.*

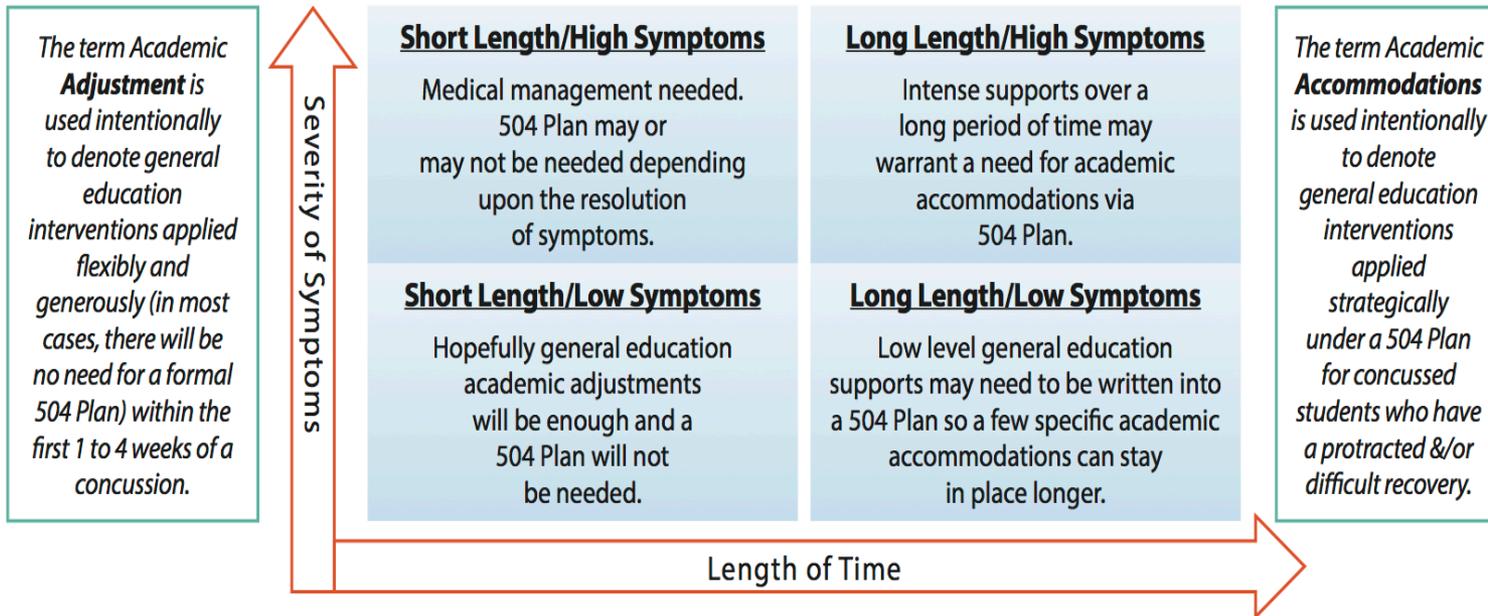


## 504 Plan Decision Formula for Concussion

© McAvoy & Eagan

*Length of Time AND/OR Severity of Symptoms PLUS Need {L &/or S + N}*

© McAvoy & Eagan



## Is there ever an appropriate time to initiate an IEP?

Have you maximized your longer-term, prescriptive and specific academic **accommodations** over months, potentially years, and now are convinced that this concussion has led to

- Permanent brain damage
- Inability for the student to benefit from general education alone?
- Student now needs specialized instruction, programming or placement?
- Student needs **modification** of the curriculum?

Student needs an IEP and/or special education.

<5%?

**In those rare circumstances, a school may consider special education for a traumatic brain injury, that started with a concussion, resulting now in a significant impairment. Follow procedures for IEP under IDEA for TBI.**

**No student ever should receive an IEP for “concussion” – they should receive an IEP for a TBI that started with a (or multiple) concussion(s).**

Return to Learn: A Schooled-Based and School-Directed RTL Protocol



**Tier 3/Intensive Level**  
 Student Need:  
 Students with moderate to severe level of TBI with need for specialized programming or **academic modifications** via Individualized Education Plan (IEP)

A few students with severe TBI will need interventions @ **Tier 3/Intensive Level (aka Special Education)**

School-based training: follow your state TBI process. In Colorado, we use:

- CDE Building Blocks

Supported on-line by:  
[www.COKidswithbraininjury.com](http://www.COKidswithbraininjury.com)

**Tier 3/Intensive Level**  
 Staff audience:  
 Related Service Providers (school nurses, school mental health, OT/PT) counselors, special educators, admin assessing for IDEA or special education

**Tier 2/Targeted Level**  
 Student Need:  
 Students with mTBI or concussion experiencing atypical recovery of > 4+ weeks or students with moderate TBI and need for **academic accommodations**

Some students with protracted recovery from mTBI/concussion or moderate TBI will need interventions @ **Tier 2/Targeted Level**

School-based training:

- GSOC Train the Trainer/Coaching Model

Supported on-line by:  
[www.GetSchooledOnConcussions.com](http://www.GetSchooledOnConcussions.com)

**Tier 2/Targeted Level**  
 Staff audience:  
 Related Service Providers (school nurses, school mental health), counselors, SLP, admin

**Tier 1/Universal Level**  
 Student Need:  
 Students with mTBI or concussion with expected typical recovery of <= 4 weeks and need for **academic adjustments**

Majority of students with a mTBI/concussion will respond to interventions at this level @ **Tier 1/Universal Level (aka General Education)**

**School-based trainings:**  
GetSchooledOnConcussions (GSOC) classroom teacher curriculum delivered via:

- Teacher Acute Concussion Tool (TACT) “just-in-time”
- Micro “Tier 1” Trainings

Supported on-line by:  
[www.GetSchooledOnConcussions.com](http://www.GetSchooledOnConcussions.com)

**Tier 1/Universal Level**  
 Staff audience:  
 Classroom Teachers/General Education

↑ RETURN TO LEARN ↑

**Students**  
 There is no Return to Learn (RTL) until there is 1<sup>st</sup> a successful and swift Return to School (R2S)!

**Return to School (R2S)**  
**Community-based trainings:**  
 REAP Community-based trainings delivered via:

- REAP Booklet

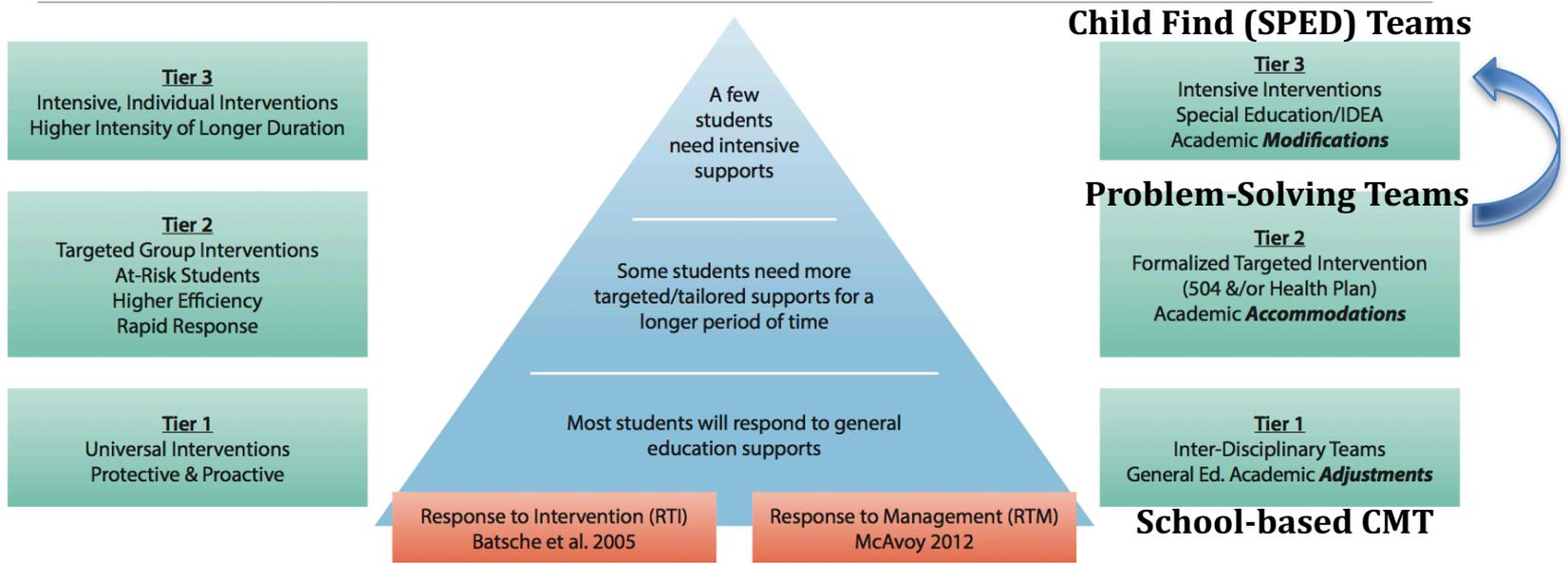
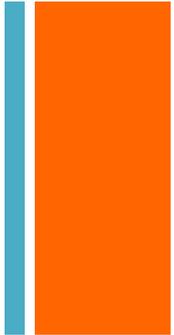
Supported on-line by: [www.REAPConcussion.com](http://www.REAPConcussion.com)

**Community Stakeholders**  
 Audience:  
 Parents  
 Healthcare Providers



# Ascending Levels Universal Level

## Multi-Tier System of Support (MTSS)



Academic: Adjustments (days to weeks) vs. Accommodations (weeks to months) vs. Modifications (months to years)

# COKIDSWITHBRAININJURY.COM



## COLORADO KIDS Brain Injury Resource Network



HOME

FOR EDUCATORS AND PROFESSIONALS

FOR PARENTS

UPCOMING EVENTS

KEY TERMS

CONTACT US



## Educators and Professionals

ENTER HERE >

## WELCOME TO THE COLORADO KIDS BRAIN INJURY RESOURCE NETWORK

The website was designed through funding from the Colorado Kids Brain Injury Resource Network. This website should serve as a tool for educators, school administrators, school psychologists, related services professionals, and families. Feel free to join in the discussion and learn more about how to support our kids in Colorado with brain injuries.

## ANNOUNCEMENTS & UPDATES

**Brain Injury in Children and Youth: A Manual for Educators.** [Click here to view manual.](#)

**CDE Concussion Management Guidelines** (Updated April 2014). [Click here to view.](#)

**Youth Brain Injury Connections Flyer.** [English Flyer.](#) [Spanish Flyer.](#)



## Parents

ENTER HERE >

# Brain Injury in Children and Youth

## A Manual for Educators

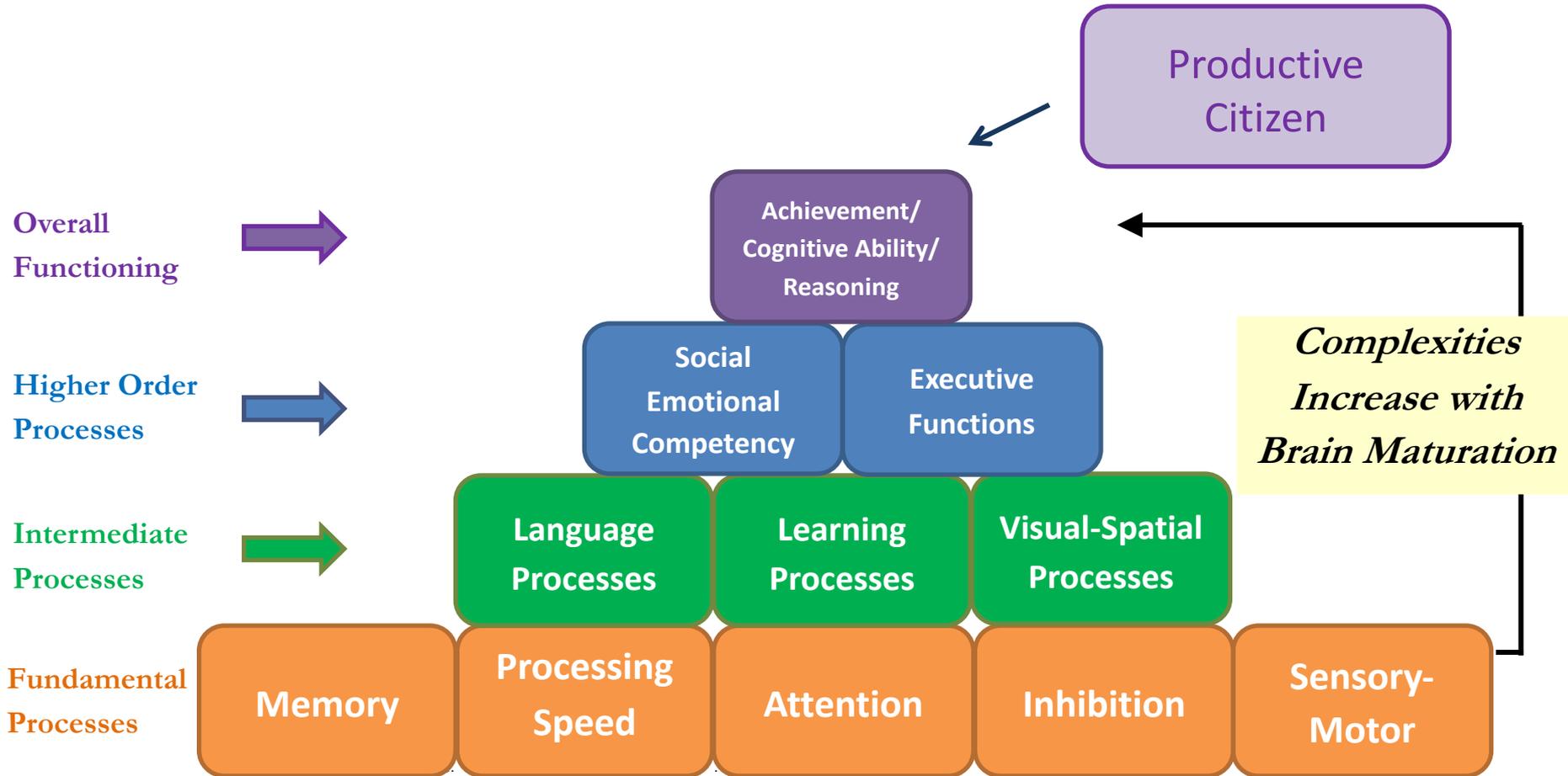


cde

COLORADO DEPARTMENT *of* EDUCATION

<http://www.cde.state.co.us/cdesped/SD-TBI.asp>

# Building Blocks of Brain Development©



The Hierarchy of Neurocognitive Functioning © - created by Peter Thompson, Ph.D. 2013, adapted from the works of Miller 2007; Reitan and Wolfson 2004; Hale and Fiorello 2004.

The Building Blocks of Brain Development © – further adapted by the CO Brain Injury Steering Committee, 2016.