



## TAEKWON DO ASSOCIATION OF ENGLAND - SAFE PRACTICE IN TAEKWON DO

Safe practice is essential to help prevent injury. Children and adults at risk are particularly vulnerable as they are still developing mentally and physically, so training methods need to be delivered in a safe and appropriate way

The health and safety of students is the instructor's responsibility. There may be other people involved e.g. sports centre staff, but in the Dojang, you have responsibility for your students. **This means you must get a first aid qualification.** Check your students' membership application and make yourself aware of any illnesses your students have and any course of action required. Always have a good first aid kit with you, and keep it well stocked.

You must have professional indemnity insurance that will cover you for legal claims against you personally by a student who has an accident in your class. In addition you may wish to take out dental or health insurance yourself.

### SAFE TRAINING PRACTICES

Prevention is better than cure! As well as being able to cope with injuries you should prevent them happening in the first place. Here are some tips.

- Ensure the Dojang is safe, the floor is clean and free of obstructions.
- Control in sparring! Obvious, but ensure it happens.
- Children should wear headguards when sparring.
- Safety equipment should be in good condition.
- Groinguards should be worn by males
- There should be adequate warm up and cool down time.
- The class should be structured properly.
- Don't let people train if they have an obvious injury.
- Jewellery should be taken off.
- Nails on hands and feet should be short.
- Mouthguards should be encouraged in sparring.
- Give good advice on technique, sparring and stretching

### THE MAIN RISK AREAS IN TAEKWON DO ARE

- Soft tissue injuries due to insufficient warm up and preparation time
- Contact during sparring
- Sprains and strains to lower limbs in sparring
- Injury to attacking tools in power test
- Strains and sprains when landing in special technique

To mitigate the risk in these areas, please refer to the risk assessments in the appendix to this document.

### **Ensure your students are thoroughly warmed up prior to intensive exercise**

A detailed breakdown on the theory and practice of class structure is given on the instructor course – you must attend one of these before you can take sole responsibility for a class.

## **SAFETY IN SPARRING**

Students should not free spar until they have learned basic blocks, footwork and have displayed they have adequate control of their kicks and punches. They should be competent in step sparring before free sparring

- Safety equipment must be worn
- Children should be grouped according to age and ability

See the risk assessment for a full analysis of risk

### **Control in sparring.**

Please be aware of the following definitions. Heavy contact is a foul in ITF Taekwon do and therefore is not allowed. All techniques should be Correct, Dynamic and Controlled – remember the CDC rule

#### **The definition of excessive contact**

“Any interpersonal contact during sparring , whether intentional or not, that is executed with care, control, sportsmanlike behaviour, an attempt to control and retract the attacking tool, and does not result in the excessive displacement of the opponent’ body (head or torso). This contact is deemed acceptable and does not result in either a warning or foul being assessed. This amount of contact is neither intended nor likely to cause damage or harm to the opponent.”

#### **The definition of heavy contact**

“Any interpersonal contact that is administered with emotion, aggression, mal-intent and/or a loss of control, or any technique that is executed without an attempt to control or retract the attacking tool, and/or that causes the opponent’s body (head or torso) to be displaced more than acceptable for the situation. This violation of the rules results in a foul being assessed against the offender.”

Refer to the ITF Concussion policy should concussion be suspected

## **SAFETY IN POWER TEST**

Ensure students:

- are competent in the technique
- know the appropriate attacking tool
- have practiced the technique on a soft pad
- are always supervised
- use an age appropriate breaking board

## **SAFETY IN SPECIAL TECHNIQUE**

Ensure students:

- are competent in the technique
- know the appropriate attacking tool
- have practiced the technique on a soft pad
- are always supervised
- use an age appropriate height to attack.

Above all, safe practice means having a suitably qualified and experienced instructor who will ensure that children are not exposed to the above risks and who can make a training session enjoyable whilst maintaining the discipline essential to learning a Martial Art.

# TAEKWON DO ASSOCIATION OF ENGLAND GENERIC RISK ASSESSMENT

Power test	
Risk	Mitigation
Injury to hands or feet by hitting the boards	<ul style="list-style-type: none"> <li>• Instructor must assess that the student has good technique before attempting to break the boards</li> <li>• Juniors should only use appropriate boards for their age</li> <li>• The amount and grade of boards should be appropriate to the age and experience of the student.</li> <li>• The boards should be in good condition</li> </ul>
Injury to hands or feet by hitting the frame	<ul style="list-style-type: none"> <li>• Instructor should assess the aptitude of the student, particularly in terms of their flexibility</li> <li>• The frame should have no sharp edges</li> <li>• The design of the frame should allow follow through after breaking the boards</li> </ul>
Turning kick	<ul style="list-style-type: none"> <li>• Assess whether the student can use the correct part of the foot to avoid hitting toes</li> <li>•</li> </ul>
punch	<ul style="list-style-type: none"> <li>• Adults only to punch boards</li> <li>• The person should have been training a minimum of 9 months and be able to do 40 knuckle press ups</li> </ul>
Side kick	<ul style="list-style-type: none"> <li>• Assess whether student can roll foot to ensure the board are hit with the bakkal</li> </ul>
Reverse turning kick	<ul style="list-style-type: none"> <li>• Technique only to be practiced by blue belt and above.</li> <li>• Student should be competent with technique and be able to show that they can use technique against soft pads with the correct form and attacking tool before attempting boards</li> </ul>
knifehand	<ul style="list-style-type: none"> <li>• Student should be competent with technique and be able to show that they can use technique against soft pads with the correct form and attacking tool before attempting boards</li> </ul>
elbow	<ul style="list-style-type: none"> <li>• Student should be competent with technique and be able to show that they can use technique against soft pads with the correct form and attacking tool before attempting boards</li> </ul>
Reverse knifehand	<ul style="list-style-type: none"> <li>• Student should be competent with technique and be able to show that they can use technique against soft pads with the correct form and attacking tool before attempting boards</li> </ul>
backfist	<ul style="list-style-type: none"> <li>• Student should be competent with technique and be able to show that they can use technique against soft pads with the correct form and attacking tool before attempting boards</li> </ul>
Side fist	<ul style="list-style-type: none"> <li>• Student should be competent with technique and be able to show that they can use technique against soft pads with the correct form and attacking tool before attempting boards</li> </ul>
Blood transfer from any cuts/ abrasions	<ul style="list-style-type: none"> <li>• Ensure boards are cleaned of any blood before another person hits them</li> </ul>

## SAFETY IN SPARRING

Risk	Mitigation
strains/sprains	<ul style="list-style-type: none"> <li>• first aiders on site</li> <li>• clear visual communication with first aiders</li> </ul>
blows from other competitors	<ul style="list-style-type: none"> <li>• sparring is non-contact for most divisions</li> <li>• appropriate groin head hand and foot pads to be worn</li> <li>• officials to adhere to competition rules</li> <li>• senior instructors to monitor refereeing standards</li> <li>• all children to wear body armour</li> <li>• all adult males to wear groin guards</li> </ul>
scratches: <ul style="list-style-type: none"> <li>• from equipment</li> <li>• from nails</li> <li>• from jewellery</li> </ul>	<ul style="list-style-type: none"> <li>• awareness and equipment check</li> </ul>
loss of balance /potential head collision with floor	<ul style="list-style-type: none"> <li>• juniors to wear headguards</li> </ul>
dehydration	<ul style="list-style-type: none"> <li>• ensure water is available</li> </ul>
collisions with table/chairs	<ul style="list-style-type: none"> <li>• ensure furniture is safe distance from ring</li> </ul>
mismatch (large competitor drawn against a small competitor)	<ul style="list-style-type: none"> <li>•</li> <li>• arrange sparring according to height weight and ability</li> </ul>
verucca	<ul style="list-style-type: none"> <li>• use of prophylactic. Veruccas must be covered up</li> </ul>
blood loss	any student who is bleeding from any injury cannot continue until the bleeding has fully stopped

## SAFETY IN SPECIAL TECHNIQUE

Risk	Mitigation
Strains, sprains when landing	Ensure students <ul style="list-style-type: none"> <li>• are competent in the technique</li> <li>• know the appropriate attacking tool</li> <li>• have practiced the technique on a soft pad</li> <li>• are always supervised</li> <li>• use an age appropriate height to attack.</li> </ul>
Kicking holder with wrong attacking tool	Ensure students <ul style="list-style-type: none"> <li>• are competent in the technique</li> <li>• know the appropriate attacking tool</li> <li>• have practiced the technique on a soft pad</li> <li>• are always supervised</li> <li>• use an age appropriate height to attack.</li> </ul>
Collision with holder	<ul style="list-style-type: none"> <li>• Position holder to minimise collision</li> <li>• Supervise practice</li> </ul>
Head injury due to loss of balance	Ensure students <ul style="list-style-type: none"> <li>• are competent in the technique</li> <li>• know the appropriate attacking tool</li> <li>• have practiced the technique on a soft pad</li> <li>• are always supervised</li> <li>• use an age appropriate height to attack.</li> </ul>



INTERNATIONAL  
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# ITF Policy

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## *ITF Tournament Concussion Policy*

### **1. Definitions**

#### **1.1 Concussion**

A concussion is a type of traumatic brain injury—or TBI—caused by a bump, blow, or jolt to the head or by a hit to the body that causes the head and brain to move rapidly back and forth.

#### **1.2 Symptoms**

The signs and symptoms of a concussion can be subtle and may not show up immediately. Symptoms can last for days, weeks or even longer. Common symptoms after a concussive traumatic brain injury are headache, loss of memory (amnesia) and confusion. The amnesia usually involves forgetting the event that caused the concussion.

Physical signs and symptoms of a concussion may include:

- Headache
- Ringing in the ears
- Nausea
- Vomiting
- Fatigue or drowsiness
- Blurry vision

Other signs and symptoms of a concussion include:

- Confusion or feeling as if in a fog
- Amnesia surrounding the traumatic event
- Dizziness or "seeing stars"

A witness may observe these signs and symptoms in the concussed person:

- Temporary loss of consciousness (though this doesn't always occur)
- Slurred speech
- Delayed response to questions
- Dazed appearance
- Forgetfulness, such as repeatedly asking the same question

You may have some symptoms of concussions immediately, and some can occur for days after the injury, such as:

- Concentration and memory complaints
- Irritability and other personality changes
- Sensitivity to light and noise
- Sleep disturbances
- Psychological adjustment problems and depression
- Disorders of taste and smell

### **1.3 Second impact syndrome**

Second impact syndrome, or SIS, happens when the brain swells rapidly shortly after a person suffers a second concussion before symptoms from an earlier concussion have subsided.

### **1.4 Chronic traumatic encephalopathy**

Chronic traumatic encephalopathy (CTE) is a progressive and fatal brain disease associated with repeated traumatic brain injuries (TBIs), including concussions and repeated blows to the head. It is also associated with the development of dementia.

### **1.5 Spinal injury**

A spinal cord injury — damage to any part of the spinal cord or nerves at the end of the spinal canal (cauda equina) — often causes permanent changes in strength, sensation and other body functions below the site of the injury.

### **1.6 Modified Maddocks questions**

A short set of questions asked at the place of the incident that tests the competitor's short term/working memory. This test can tell the Medical Team if the competitor is concussed instantly by ruling concussion in, not out. For example:

- What round are you competing in?
- What did you have for breakfast?
- What venue are we in?
- Which country/club are you competing against?
- What was the last technique you performed?

### **1.7 SCAT 5 (appendix 1 and appendix 2)**

The SCAT5 (Sport Concussion Assessment Tool) is a standardized tool for evaluating for a suspected concussion and can be used on individuals aged 13 years and older. It supersedes the original SCAT (2005), the SCAT2 (2009), and the SCAT3 (2013).



The Child Sport Concussion Assessment Tool (Child SCAT5) is designed as a standardised tool to screen for concussion with children aged from 5 to 12.

The SCAT5 is designed for use by medical professionals, if a concussion is suspected, the competitor should undergo medical assessment by a medical doctor, nurse practitioner or paramedic trained specifically in recognising sports concussion.

The SCAT5 scoring summary includes the following sections:

- Red flags
- Memory assessment – Modified Maddocks Questions
- Glasgow Coma Scale (GCS) examination
- Cervical spine assessment
- Symptom evaluation
- Cognitive screening
- Neurological screening
- Balance examination
- Delayed recall

## **2. Purpose**

### **2.1 Aim and scope of application**

#### **Recognise and Remove**

The aim of this policy is to identify how to recognise concussion and when to remove a competitor from competition with a suspected or confirmed concussion.

According to Davis GA, et al. (2017), “a head impact by either a direct blow or indirect transmission of force can be associated with a serious and potentially fatal brain injury”.

In addition, the aim is to implement a framework that covers the following points (see appendix 3):

- Preventative rules;
- Enforcement of rules;
- Recognition of concussion rule;
- Removal from tournament rule;
- Graduated return to contact sport rule;
- Recording of data;
- Education;
- Head injury surveillance;

The surveillance will be an ongoing research project that will provide appropriate data to assist in future modifications to the rules.

## **2.2 Why does the ITF have a Concussion Policy?**

a) The purpose of this policy is to bring improved levels of safety within tournaments for the protection of the competitor. Without a concussion policy, this leaves the potential for competitors to sustain a concussion and be allowed to continue to fight and compete, therefore increasing risks of serious injury or death. Once concussion is recognised, then the competitor must be removed from the competition, and further medical assistance given in line with the severity of the injury.

b) Rugby, Football and other sports now have official concussion recognition tools - such as SCAT5 - that are used by health care professionals when recognising and managing concussion.

c) The key reason for having a graduated return to contact sports is to give the brain the time to heal and recover. The current consensus is 3 weeks.

d) We need to ensure that ongoing education continues at all levels, because if we don't know how to recognise, then we don't know when to remove a competitor from competition.

e) In recent years concussion research has identified that coaches are often poorly equipped with the knowledge and skills to recognise concussion:

*The likely absence of health-care professionals during training was confirmed by 68.5% of coaches, and athletes declared that self-diagnosis (79%) and coaches' diagnosis (43.3%) were the most used method of suspected concussion assessment. Merely 5.7% of coaches properly recognized the level of traumatic brain injury a concussion represents, 68.8% were unfamiliar with any sideline assessment tools, and only 14.3% often seek out concussion knowledge. (Patricios et al., 2018: 635)*

It is also important to add that all ITF umpires must have knowledge of recognising concussion as part of their training so as to identify when an incident occurs. Their feedback will be essential in part of the diagnosis from the medical professionals.

## **3. Behavioural compliance with the policy**

Compliance with this policy ensures the health and wellbeing of competitors at many levels. Cooperation from umpires, coaches and instructors makes certain that the medical professionals in charge of overseeing ITF events can ensure the competitors to compete in a safe environment with a robust policy that protects them including any required return to play protocol.

a) Our event organisers, Tournament Committee, Umpire Committee, Coaches Committee and Athletes Committee treat concussion very seriously so as to minimize the risk to our members.

b) That we recognise the sign and symptoms of concussion.

- c) We train our Umpires, Coaches and Instructors to recognize the signs and symptoms of concussion as well as knowledge on what they can do to manage head injuries.
- d) The on-site medical staff at all of our ITF Tournaments are fully trained in sports related head injuries/concussion and the implementation of this policy.
- e) Our event Committees, Umpires and Coaches accept the advice and guidance from the official on-site event trained medical team.
- f) Our Athletes accept the advice and guidance from the official trained on-site event medical team and if the diagnosis of concussion has been recognized then comply with the policy on a safe graduated return to play.
- g) That we record all head injuries that occur in ITF Tournaments.
- h) That we ensure a safe procedure for the return to play for any competitor who has received a concussion.

#### **4. Non-Compliant Behaviour**

- a) That we do not run ITF Tournaments without sufficient and suitably qualified health care professionals (medical staff) who are trained to recognise a sports injury concussion.
- c) Umpires, coaches and athletes do not act against the advice of the trained on-site event medical team who have diagnosed concussion.

### **5. Process**

#### **5.1 Training & education**

All Umpires and Coaches will receive appropriate training regarding the recognition of the signs and symptoms of concussion and the long term effects at all levels. They will be trained in the process of SCAT5 so they understand their position in the process.

#### **5.2 Official on-site event medical team**

- a) All ITF Tournaments will use medical staff who are trained to recognise, remove and manage competitors with sports-related head injuries/concussion. With at least one medical professional in the team to have one of the following qualifications: Doctor, paramedic or health care professional with sports specific concussion training.
- b) The on-site event medical team is selected by the host with the number of agreed staff required for the event based on the number of projected competitors and rings.

Relevant qualifications must also be sent to the Tournament Committee 3 months in advance.

c) The on-site event medical team will receive a copy of this policy document 3 months before the event, that each member must read and agree with. (Three months is given in case a translation of the document is required).

d) The on-site event medical team will provide an event medical plan (EMP) to the Tournament Committee before the start of the event. This will include details of minimum agreed numbers of the medical team and their qualifications; the name of the medical lead; minimum equipment; a daily team debrief and a daily mock evacuation simulation of an injured competitor (such as spinal/head injury and cardiac arrest).

### **5.3 During the event**

a) If there is a suspected concussion the official on-site event medical team will communicate firstly with the athlete asking Modified Maddocks questions then if required they will ask the Umpires and Coaches for their opinions.

b) If there is a suspected concussion and the trained medical staff need more time than the tournament allows to assess the competitor, then the competitor must be removed by the on-site medical team for further assessment using currently recognised concussion assessment tools such as those recommended by the 5<sup>th</sup> International Consensus Conference on Concussion in Sport. These include:

- The Child Sport Concussion Assessment Tool 5<sup>th</sup> Edition (Child SCAT5) – for children aged 12 years and younger;
- The Sport Concussion Assessment Tool 5<sup>th</sup> Edition (SCAT5) – for persons aged 13 years and older.

c) The competitor will be removed from all further events in that competition when a diagnosis of concussion or suspected concussion is made by the on-site medical team. The on-site event medical team make a clinical diagnosis of concussion – as this is a clinical decision. It is also the final decision of the on-site event medical team whether a competitor has been diagnosed with concussion.

d) The on-site event medical team may refer the competitor on for further medical assessment or recommend they go to the local hospital.

e) The on-site event medical team will inform the Tournament Committee of any competitor with concussion or a suspected concussion. This will be done officially in written form or by email before the end of the day.

f) The Tournament Committee will keep the data in the form of a register of head injuries and will check it at the beginning of each day's events to ensure concussed competitors are not participating.

## **5.4 Graduated return to contact sport**

- a) If a diagnosis of concussion is made, then the competitor must be removed from all further events in that competition and must not return to contact sport for three (3) weeks, or until medically cleared by a sports concussion doctor. The instructor or coach then sends an official communication to the Tournament Committee to confirm the return to contact sport.
- b) The competitor may need to seek further medical advice when returning to their country they are residing in.
- c) If the diagnosis indicates further assessment at hospital, then the competitor must comply with this recommendation.

## **6. Controls to check compliance**

### **6.1 Register of all head injuries**

- a) It is recommended that records of individuals' concussions be kept for at least 10 years from the date of the incident in a centralised head injuries register.
- b) All data in the head injuries register will be held unnamed for further research and development with periodic analysis by the Tournament Committee and the Medical and Anti-Doping Committee and a periodic review of the rules regarding concussion and the mechanisms of concussion injury considering the data and evidence from the register.

### **6.2 Ongoing controls**

The Audit, Risk and Compliance Committee checks periodically that the register is updated and being used.

## **7. Approval and version control**

This policy was approved by the Board of Directors on March 21<sup>st</sup>, 2021.

Date	Description	Version
21/03/2021	Tournament Concussion Policy	1

## **Appendix 1**

SCAT 5 tool, <https://bjsm.bmj.com/content/bjsports/early/2017/04/26/bjsports-2017-097506SCAT5.full.pdf>

## **Appendix 2**

Child SCAT 5 tool, <https://bjsm.bmj.com/content/51/11/862>

## **Appendix 3**

Framework

## **Appendix 4**

Example Event Medical Plan

Equipment medical team will supply and use

Mock Evacs

Team debrief

## **References**

[https://www.cdc.gov/headsup/basics/concussion\\_what.html](https://www.cdc.gov/headsup/basics/concussion_what.html)

Davis GA, et al., (2017) <https://bjsm.bmj.com/content/51/11/859>

Patricios, et al., (2018) <https://bjsm.bmj.com/content/52/10/635.abstract>

# SCAT5<sup>®</sup>

## SPORT CONCUSSION ASSESSMENT TOOL – 5TH EDITION

DEVELOPED BY THE CONCUSSION IN SPORT GROUP

FOR USE BY MEDICAL PROFESSIONALS ONLY

supported by



### Patient details

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Address: \_\_\_\_\_

ID number: \_\_\_\_\_

Examiner: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Time: \_\_\_\_\_

## WHAT IS THE SCAT5?

**The SCAT5 is a standardized tool for evaluating concussions designed for use by physicians and licensed healthcare professionals<sup>1</sup>. The SCAT5 cannot be performed correctly in less than 10 minutes.**

If you are not a physician or licensed healthcare professional, please use the Concussion Recognition Tool 5 (CRT5). The SCAT5 is to be used for evaluating athletes aged 13 years and older. For children aged 12 years or younger, please use the Child SCAT5.

Preseason SCAT5 baseline testing can be useful for interpreting post-injury test scores, but is not required for that purpose. Detailed instructions for use of the SCAT5 are provided on page 7. Please read through these instructions carefully before testing the athlete. Brief verbal instructions for each test are given in italics. The only equipment required for the tester is a watch or timer.

**This tool may be freely copied in its current form for distribution to individuals, teams, groups and organizations. It should not be altered in any way, re-branded or sold for commercial gain. Any revision, translation or reproduction in a digital form requires specific approval by the Concussion in Sport Group.**

## Recognise and Remove

A head impact by either a direct blow or indirect transmission of force can be associated with a serious and potentially fatal brain injury. If there are significant concerns, including any of the red flags listed in Box 1, then activation of emergency procedures and urgent transport to the nearest hospital should be arranged.

### Key points

- Any athlete with suspected concussion should be REMOVED FROM PLAY, medically assessed and monitored for deterioration. No athlete diagnosed with concussion should be returned to play on the day of injury.
- If an athlete is suspected of having a concussion and medical personnel are not immediately available, the athlete should be referred to a medical facility for urgent assessment.
- Athletes with suspected concussion should not drink alcohol, use recreational drugs and should not drive a motor vehicle until cleared to do so by a medical professional.
- Concussion signs and symptoms evolve over time and it is important to consider repeat evaluation in the assessment of concussion.
- The diagnosis of a concussion is a clinical judgment, made by a medical professional. The SCAT5 should NOT be used by itself to make, or exclude, the diagnosis of concussion. An athlete may have a concussion even if their SCAT5 is "normal".

### Remember:

- The basic principles of first aid (danger, response, airway, breathing, circulation) should be followed.
- Do not attempt to move the athlete (other than that required for airway management) unless trained to do so.
- Assessment for a spinal cord injury is a critical part of the initial on-field assessment.
- Do not remove a helmet or any other equipment unless trained to do so safely.

## IMMEDIATE OR ON-FIELD ASSESSMENT

The following elements should be assessed for all athletes who are suspected of having a concussion prior to proceeding to the neurocognitive assessment and ideally should be done on-field after the first first aid / emergency care priorities are completed.

If any of the "Red Flags" or observable signs are noted after a direct or indirect blow to the head, the athlete should be immediately and safely removed from participation and evaluated by a physician or licensed healthcare professional.

Consideration of transportation to a medical facility should be at the discretion of the physician or licensed healthcare professional.

The GCS is important as a standard measure for all patients and can be done serially if necessary in the event of deterioration in conscious state. The Maddocks questions and cervical spine exam are critical steps of the immediate assessment; however, these do not need to be done serially.

### STEP 1: RED FLAGS

#### RED FLAGS:

- Neck pain or tenderness
- Double vision
- Weakness or tingling/burning in arms or legs
- Severe or increasing headache
- Seizure or convulsion
- Loss of consciousness
- Deteriorating conscious state
- Vomiting
- Increasingly restless, agitated or combative

### STEP 2: OBSERVABLE SIGNS

Witnessed ☐ Observed on Video ☐

	Y	N
Lying motionless on the playing surface	Y	N
Balance / gait difficulties / motor incoordination: stumbling, slow / laboured movements	Y	N
Disorientation or confusion, or an inability to respond appropriately to questions	Y	N
Blank or vacant look	Y	N
Facial injury after head trauma	Y	N

### STEP 3: MEMORY ASSESSMENT MADDOCKS QUESTIONS<sup>2</sup>

"I am going to ask you a few questions, please listen carefully and give your best effort. First, tell me what happened?"

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Mark Y for correct answer / N for incorrect

What venue are we at today?	Y	N
Which half is it now?	Y	N
Who scored last in this match?	Y	N
What team did you play last week / game?	Y	N
Did your team win the last game?	Y	N

Note: Appropriate sport-specific questions may be substituted.

Name: \_\_\_\_\_  
 DOB: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 ID number: \_\_\_\_\_  
 Examiner: \_\_\_\_\_  
 Date: \_\_\_\_\_

### STEP 4: EXAMINATION

#### GLASGOW COMA SCALE (GCS)<sup>3</sup>

Time of assessment			
Date of assessment			
<b>Best eye response (E)</b>			
No eye opening	1	1	1
Eye opening in response to pain	2	2	2
Eye opening to speech	3	3	3
Eyes opening spontaneously	4	4	4
<b>Best verbal response (V)</b>			
No verbal response	1	1	1
Incomprehensible sounds	2	2	2
Inappropriate words	3	3	3
Confused	4	4	4
Oriented	5	5	5
<b>Best motor response (M)</b>			
No motor response	1	1	1
Extension to pain	2	2	2
Abnormal flexion to pain	3	3	3
Flexion / Withdrawal to pain	4	4	4
Localizes to pain	5	5	5
Obeys commands	6	6	6
Glasgow Coma score (E + V + M)			

### CERVICAL SPINE ASSESSMENT

Does the athlete report that their neck is pain free at rest?	Y	N
If there is NO neck pain at rest, does the athlete have a full range of ACTIVE pain free movement?	Y	N
Is the limb strength and sensation normal?	Y	N

**In a patient who is not lucid or fully conscious, a cervical spine injury should be assumed until proven otherwise.**



## OFFICE OR OFF-FIELD ASSESSMENT

Please note that the neurocognitive assessment should be done in a distraction-free environment with the athlete in a resting state.

### STEP 1: ATHLETE BACKGROUND

Sport / team / school: \_\_\_\_\_

Date / time of injury: \_\_\_\_\_

Years of education completed: \_\_\_\_\_

Age: \_\_\_\_\_

Gender: M / F / Other

Dominant hand: left / neither / right

How many diagnosed concussions has the athlete had in the past?: \_\_\_\_\_

When was the most recent concussion?: \_\_\_\_\_

How long was the recovery (time to being cleared to play) from the most recent concussion?: \_\_\_\_\_ (days)

#### Has the athlete ever been:

Hospitalized for a head injury?	Yes	No
Diagnosed / treated for headache disorder or migraines?	Yes	No
Diagnosed with a learning disability / dyslexia?	Yes	No
Diagnosed with ADD / ADHD?	Yes	No
Diagnosed with depression, anxiety or other psychiatric disorder?	Yes	No

Current medications? If yes, please list:

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Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Address: \_\_\_\_\_

ID number: \_\_\_\_\_

Examiner: \_\_\_\_\_

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

2

### STEP 2: SYMPTOM EVALUATION

The athlete should be given the symptom form and asked to read this instruction paragraph out loud then complete the symptom scale. For the baseline assessment, the athlete should rate his/her symptoms based on how he/she typically feels and for the post injury assessment the athlete should rate their symptoms at this point in time.

Please Check: ☐ Baseline ☐ Post-Injury

Please hand the form to the athlete

	none	mild	moderate		severe		
Headache	0	1	2	3	4	5	6
"Pressure in head"	0	1	2	3	4	5	6
Neck Pain	0	1	2	3	4	5	6
Nausea or vomiting	0	1	2	3	4	5	6
Dizziness	0	1	2	3	4	5	6
Blurred vision	0	1	2	3	4	5	6
Balance problems	0	1	2	3	4	5	6
Sensitivity to light	0	1	2	3	4	5	6
Sensitivity to noise	0	1	2	3	4	5	6
Feeling slowed down	0	1	2	3	4	5	6
Feeling like "in a fog"	0	1	2	3	4	5	6
"Don't feel right"	0	1	2	3	4	5	6
Difficulty concentrating	0	1	2	3	4	5	6
Difficulty remembering	0	1	2	3	4	5	6
Fatigue or low energy	0	1	2	3	4	5	6
Confusion	0	1	2	3	4	5	6
Drowsiness	0	1	2	3	4	5	6
More emotional	0	1	2	3	4	5	6
Irritability	0	1	2	3	4	5	6
Sadness	0	1	2	3	4	5	6
Nervous or Anxious	0	1	2	3	4	5	6
Trouble falling asleep (if applicable)	0	1	2	3	4	5	6

Total number of symptoms: \_\_\_\_\_ of 22

Symptom severity score: \_\_\_\_\_ of 132

Do your symptoms get worse with physical activity? Y N

Do your symptoms get worse with mental activity? Y N

If 100% is feeling perfectly normal, what percent of normal do you feel?

If not 100%, why?

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Please hand form back to examiner

## STEP 3: COGNITIVE SCREENING

Standardised Assessment of Concussion (SAC)<sup>4</sup>

### ORIENTATION

What month is it?	0	1
What is the date today?	0	1
What is the day of the week?	0	1
What year is it?	0	1
What time is it right now? (within 1 hour)	0	1
<b>Orientation score</b>	of 5	

### IMMEDIATE MEMORY

The Immediate Memory component can be completed using the traditional 5-word per trial list or optionally using 10-words per trial to minimise any ceiling effect. All 3 trials must be administered irrespective of the number correct on the first trial. Administer at the rate of one word per second.

Please choose EITHER the 5 or 10 word list groups and circle the specific word list chosen for this test.

I am going to test your memory. I will read you a list of words and when I am done, repeat back as many words as you can remember, in any order. For Trials 2 & 3: I am going to repeat the same list again. Repeat back as many words as you can remember in any order, even if you said the word before.

List						Score (of 5)		
Alternate 5 word lists						Trial 1	Trial 2	Trial 3
A	Finger	Penny	Blanket	Lemon	Insect			
B	Candle	Paper	Sugar	Sandwich	Wagon			
C	Baby	Monkey	Perfume	Sunset	Iron			
D	Elbow	Apple	Carpet	Saddle	Bubble			
E	Jacket	Arrow	Pepper	Cotton	Movie			
F	Dollar	Honey	Mirror	Saddle	Anchor			
<b>Immediate Memory Score</b>						of 15		
<b>Time that last trial was completed</b>								

List						Score (of 10)		
Alternate 10 word lists						Trial 1	Trial 2	Trial 3
G	Finger	Penny	Blanket	Lemon	Insect			
	Candle	Paper	Sugar	Sandwich	Wagon			
H	Baby	Monkey	Perfume	Sunset	Iron			
	Elbow	Apple	Carpet	Saddle	Bubble			
I	Jacket	Arrow	Pepper	Cotton	Movie			
	Dollar	Honey	Mirror	Saddle	Anchor			
<b>Immediate Memory Score</b>						of 30		
<b>Time that last trial was completed</b>								

Name: \_\_\_\_\_  
 DOB: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 ID number: \_\_\_\_\_  
 Examiner: \_\_\_\_\_  
 Date: \_\_\_\_\_

## CONCENTRATION

### DIGITS BACKWARDS

Please circle the Digit list chosen (A, B, C, D, E, F). Administer at the rate of one digit per second reading DOWN the selected column.

I am going to read a string of numbers and when I am done, you repeat them back to me in reverse order of how I read them to you. For example, if I say 7-1-9, you would say 9-1-7.

Concentration Number Lists (circle one)					
List A	List B	List C			
4-9-3	5-2-6	1-4-2	Y	N	0
6-2-9	4-1-5	6-5-8	Y	N	1
3-8-1-4	1-7-9-5	6-8-3-1	Y	N	0
3-2-7-9	4-9-6-8	3-4-8-1	Y	N	1
6-2-9-7-1	4-8-5-2-7	4-9-1-5-3	Y	N	0
1-5-2-8-6	6-1-8-4-3	6-8-2-5-1	Y	N	1
7-1-8-4-6-2	8-3-1-9-6-4	3-7-6-5-1-9	Y	N	0
5-3-9-1-4-8	7-2-4-8-5-6	9-2-6-5-1-4	Y	N	1
List D	List E	List F			
7-8-2	3-8-2	2-7-1	Y	N	0
9-2-6	5-1-8	4-7-9	Y	N	1
4-1-8-3	2-7-9-3	1-6-8-3	Y	N	0
9-7-2-3	2-1-6-9	3-9-2-4	Y	N	1
1-7-9-2-6	4-1-8-6-9	2-4-7-5-8	Y	N	0
4-1-7-5-2	9-4-1-7-5	8-3-9-6-4	Y	N	1
2-6-4-8-1-7	6-9-7-3-8-2	5-8-6-2-4-9	Y	N	0
8-4-1-9-3-5	4-2-7-9-3-8	3-1-7-8-2-6	Y	N	1
<b>Digits Score:</b>			of 4		

## MONTHS IN REVERSE ORDER

Now tell me the months of the year in reverse order. Start with the last month and go backward. So you'll say December, November. Go ahead.

Dec - Nov - Oct - Sept - Aug - Jul - Jun - May - Apr - Mar - Feb - Jan	0	1
<b>Months Score</b>	of 1	
<b>Concentration Total Score (Digits + Months)</b>	of 5	

4

## STEP 4: NEUROLOGICAL SCREEN

See the instruction sheet (page 7) for details of test administration and scoring of the tests.

Can the patient read aloud (e.g. symptom check-list) and follow instructions without difficulty?	Y	N
Does the patient have a full range of pain-free PASSIVE cervical spine movement?	Y	N
Without moving their head or neck, can the patient look side-to-side and up-and-down without double vision?	Y	N
Can the patient perform the finger nose coordination test normally?	Y	N
Can the patient perform tandem gait normally?	Y	N

## BALANCE EXAMINATION

### Modified Balance Error Scoring System (mBESS) testing<sup>5</sup>

Which foot was tested (i.e. which is the non-dominant foot) ☐ Left ☐ Right

Testing surface (hard floor, field, etc.) \_\_\_\_\_

Footwear (shoes, barefoot, braces, tape, etc.) \_\_\_\_\_

Condition	Errors
<b>Double leg stance</b>	_____ of 10
<b>Single leg stance (non-dominant foot)</b>	_____ of 10
<b>Tandem stance (non-dominant foot at the back)</b>	_____ of 10
<b>Total Errors</b>	_____ of 30

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Address: \_\_\_\_\_

ID number: \_\_\_\_\_

Examiner: \_\_\_\_\_

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

5

## STEP 5: DELAYED RECALL:

The delayed recall should be performed after 5 minutes have elapsed since the end of the Immediate Recall section. Score 1 pt. for each correct response.

*Do you remember that list of words I read a few times earlier? Tell me as many words from the list as you can remember in any order.*

Time Started \_\_\_\_\_

Please record each word correctly recalled. Total score equals number of words recalled.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Total number of words recalled accurately: \_\_\_\_\_ of 5 or \_\_\_\_\_ of 10

6

## STEP 6: DECISION

Domain	Date & time of assessment:		
Symptom number (of 22)			
Symptom severity score (of 132)			
Orientation (of 5)			
Immediate memory	_____ of 15 _____ of 30	_____ of 15 _____ of 30	_____ of 15 _____ of 30
Concentration (of 5)			
Neuro exam	Normal Abnormal	Normal Abnormal	Normal Abnormal
Balance errors (of 30)			
Delayed Recall	_____ of 5 _____ of 10	_____ of 5 _____ of 10	_____ of 5 _____ of 10

Date and time of injury: \_\_\_\_\_

If the athlete is known to you prior to their injury, are they different from their usual self?

☐ Yes ☐ No ☐ Unsure ☐ Not Applicable

(If different, describe why in the clinical notes section)

Concussion Diagnosed?

☐ Yes ☐ No ☐ Unsure ☐ Not Applicable

If re-testing, has the athlete improved?

☐ Yes ☐ No ☐ Unsure ☐ Not Applicable

**I am a physician or licensed healthcare professional and I have personally administered or supervised the administration of this SCAT5.**

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

Name: \_\_\_\_\_

Title: \_\_\_\_\_

Registration number (if applicable): \_\_\_\_\_

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

**SCORING ON THE SCAT5 SHOULD NOT BE USED AS A STAND-ALONE METHOD TO DIAGNOSE CONCUSSION, MEASURE RECOVERY OR MAKE DECISIONS ABOUT AN ATHLETE'S READINESS TO RETURN TO COMPETITION AFTER CONCUSSION.**

**CLINICAL NOTES:**

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Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Address: \_\_\_\_\_

ID number: \_\_\_\_\_

Examiner: \_\_\_\_\_

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

[illegible]

## CONCUSSION INJURY ADVICE

**(To be given to the person monitoring the concussed athlete)**

This patient has received an injury to the head. A careful medical examination has been carried out and no sign of any serious complications has been found. Recovery time is variable across individuals and the patient will need monitoring for a further period by a responsible adult. Your treating physician will provide guidance as to this timeframe.

**If you notice any change in behaviour, vomiting, worsening headache, double vision or excessive drowsiness, please telephone your doctor or the nearest hospital emergency department immediately.**

Other important points:

**Initial rest: Limit physical activity to routine daily activities (avoid exercise, training, sports) and limit activities such as school, work, and screen time to a level that does not worsen symptoms.**

- 1) Avoid alcohol
- 2) Avoid prescription or non-prescription drugs without medical supervision. Specifically:
  - a) Avoid sleeping tablets
  - b) Do not use aspirin, anti-inflammatory medication or stronger pain medications such as narcotics
- 3) Do not drive until cleared by a healthcare professional.
- 4) Return to play/sport requires clearance by a healthcare professional.

**Clinic phone number:** \_\_\_\_\_

Patient's name: \_\_\_\_\_

Date / time of injury: \_\_\_\_\_

Date / time of medical review: \_\_\_\_\_

Healthcare Provider: \_\_\_\_\_

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Contact details or stamp

## INSTRUCTIONS

Words in *Italics* throughout the SCAT5 are the instructions given to the athlete by the clinician

### Symptom Scale

The time frame for symptoms should be based on the type of test being administered. At baseline it is advantageous to assess how an athlete "typically" feels whereas during the acute/post-acute stage it is best to ask how the athlete feels at the time of testing.

The symptom scale should be completed by the athlete, not by the examiner. In situations where the symptom scale is being completed after exercise, it should be done in a resting state, generally by approximating his/her resting heart rate.

For total number of symptoms, maximum possible is 22 except immediately post injury, if sleep item is omitted, which then creates a maximum of 21.

For Symptom severity score, add all scores in table, maximum possible is 22 x 6 = 132, except immediately post injury if sleep item is omitted, which then creates a maximum of 21x6=126.

### Immediate Memory

The Immediate Memory component can be completed using the traditional 5-word per trial list or, optionally, using 10-words per trial. The literature suggests that the Immediate Memory has a notable ceiling effect when a 5-word list is used. In settings where this ceiling is prominent, the examiner may wish to make the task more difficult by incorporating two 5-word groups for a total of 10 words per trial. In this case, the maximum score per trial is 10 with a total trial maximum of 30.

Choose one of the word lists (either 5 or 10). Then perform 3 trials of immediate memory using this list.

Complete all 3 trials regardless of score on previous trials.

*"I am going to test your memory. I will read you a list of words and when I am done, repeat back as many words as you can remember, in any order."* The words must be read at a rate of one word per second.

Trials 2 & 3 MUST be completed regardless of score on trial 1 & 2.

Trials 2 & 3:

*"I am going to repeat the same list again. Repeat back as many words as you can remember in any order, even if you said the word before."*

Score 1 pt. for each correct response. Total score equals sum across all 3 trials. Do NOT inform the athlete that delayed recall will be tested.

### Concentration

#### Digits backward

Choose one column of digits from lists A, B, C, D, E or F and administer those digits as follows:

Say: *"I am going to read a string of numbers and when I am done, you repeat them back to me in reverse order of how I read them to you. For example, if I say 7-1-9, you would say 9-1-7."*

Begin with first 3 digit string.

If correct, circle "Y" for correct and go to next string length. If incorrect, circle "N" for the first string length and read trial 2 in the same string length. One point possible for each string length. Stop after incorrect on both trials (2 N's) in a string length. The digits should be read at the rate of one per second.

### Months in reverse order

*"Now tell me the months of the year in reverse order. Start with the last month and go backward. So you'll say December, November ... Go ahead"*

1 pt. for entire sequence correct

### Delayed Recall

The delayed recall should be performed after 5 minutes have elapsed since the end of the Immediate Recall section.

*"Do you remember that list of words I read a few times earlier? Tell me as many words from the list as you can remember in any order."*

Score 1 pt. for each correct response

### Modified Balance Error Scoring System (mBESS)<sup>5</sup> testing

This balance testing is based on a modified version of the Balance Error Scoring System (BESS)<sup>5</sup>. A timing device is required for this testing.

Each of 20-second trial/stance is scored by counting the number of errors. The examiner will begin counting errors only after the athlete has assumed the proper start position. The modified BESS is calculated by adding one error point for each error during the three 20-second tests. The maximum number of errors for any single condition is 10. If the athlete commits multiple errors simultaneously, only

one error is recorded but the athlete should quickly return to the testing position, and counting should resume once the athlete is set. Athletes that are unable to maintain the testing procedure for a minimum of five seconds at the start are assigned the highest possible score, ten, for that testing condition.

OPTION: For further assessment, the same 3 stances can be performed on a surface of medium density foam (e.g., approximately 50cm x 40cm x 6cm).

### Balance testing – types of errors

- |                                 |   |   |
|---------------------------------|---|---|
| 1. Hands lifted off iliac crest | 3. Step, stumble, or fall                 | 5. Lifting forefoot or heel               |
| 2. Opening eyes                 | 4. Moving hip into > 30 degrees abduction | 6. Remaining out of test position > 5 sec |

*"I am now going to test your balance. Please take your shoes off (if applicable), roll up your pant legs above ankle (if applicable), and remove any ankle taping (if applicable). This test will consist of three twenty second tests with different stances."*

(a) Double leg stance:

*"The first stance is standing with your feet together with your hands on your hips and with your eyes closed. You should try to maintain stability in that position for 20 seconds. I will be counting the number of times you move out of this position. I will start timing when you are set and have closed your eyes."*

(b) Single leg stance:

*"If you were to kick a ball, which foot would you use? [This will be the dominant foot] Now stand on your non-dominant foot. The dominant leg should be held in approximately 30 degrees of hip flexion and 45 degrees of knee flexion. Again, you should try to maintain stability for 20 seconds with your hands on your hips and your eyes closed. I will be counting the number of times you move out of this position. If you stumble out of this position, open your eyes and return to the start position and continue balancing. I will start timing when you are set and have closed your eyes."*

(c) Tandem stance:

*"Now stand heel-to-toe with your non-dominant foot in back. Your weight should be evenly distributed across both feet. Again, you should try to maintain stability for 20 seconds with your hands on your hips and your eyes closed. I will be counting the number of times you move out of this position. If you stumble out of this position, open your eyes and return to the start position and continue balancing. I will start timing when you are set and have closed your eyes."*

### Tandem Gait

Participants are instructed to stand with their feet together behind a starting line (the test is best done with footwear removed). Then, they walk in a forward direction as quickly and as accurately as possible along a 38mm wide (sports tape), 3 metre line with an alternate foot heel-to-toe gait ensuring that they approximate their heel and toe on each step. Once they cross the end of the 3m line, they turn 180 degrees and return to the starting point using the same gait. Athletes fail the test if they step off the line, have a separation between their heel and toe, or if they touch or grab the examiner or an object.

### Finger to Nose

*"I am going to test your coordination now. Please sit comfortably on the chair with your eyes open and your arm (either right or left) outstretched (shoulder flexed to 90 degrees and elbow and fingers extended), pointing in front of you. When I give a start signal, I would like you to perform five successive finger to nose repetitions using your index finger to touch the tip of the nose, and then return to the starting position, as quickly and as accurately as possible."*

### References

1. McCrory et al. Consensus Statement On Concussion In Sport – The 5th International Conference On Concussion In Sport Held In Berlin, October 2016. British Journal of Sports Medicine 2017 (available at [www.bjsm.bmj.com](http://www.bjsm.bmj.com))
2. Maddocks, DL; Dicker, GD; Saling, MM. The assessment of orientation following concussion in athletes. Clinical Journal of Sport Medicine 1995; 5: 32-33
3. Jennett, B., Bond, M. Assessment of outcome after severe brain damage: a practical scale. Lancet 1975; i: 480-484
4. McCrea M. Standardized mental status testing of acute concussion. Clinical Journal of Sport Medicine. 2001; 11: 176-181
5. Guskiewicz KM. Assessment of postural stability following sport-related concussion. Current Sports Medicine Reports. 2003; 2: 24-30

## CONCUSSION INFORMATION

**Any athlete suspected of having a concussion should be removed from play and seek medical evaluation.**

### Signs to watch for

Problems could arise over the first 24-48 hours. The athlete should not be left alone and must go to a hospital at once if they experience:

- Worsening headache
- Repeated vomiting
- Weakness or numbness in arms or legs
- Drowsiness or inability to be awakened
- Unusual behaviour or confusion or irritable
- Unsteadiness on their feet.
- Inability to recognize people or places
- Seizures (arms and legs jerk uncontrollably)
- Slurred speech

**Consult your physician or licensed healthcare professional after a suspected concussion. Remember, it is better to be safe.**

### Rest & Rehabilitation

After a concussion, the athlete should have physical rest and relative cognitive rest for a few days to allow their symptoms to improve. In most cases, after no more than a few days of rest, the athlete should gradually increase their daily activity level as long as their symptoms do not worsen. Once the athlete is able to complete their usual daily activities without concussion-related symptoms, the second step of the return to play/sport progression can be started. The athlete should not return to play/sport until their concussion-related symptoms have resolved and the athlete has successfully returned to full school/learning activities.

When returning to play/sport, the athlete should follow a stepwise, **medically managed exercise progression, with increasing amounts of exercise.** For example:

### Graduated Return to Sport Strategy

Exercise step	Functional exercise at each step	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 play/sport	Normal game play.	

In this example, it would be typical to have 24 hours (or longer) for each step of the progression. If any symptoms worsen while exercising, 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).

**Written clearance should be provided by a healthcare professional before return to play/sport as directed by local laws and regulations.**

### Graduated Return to School Strategy

Concussion may affect the ability to learn at school. The athlete may need to miss a few days of school after a concussion. When going back to school, some athletes may need to go back gradually and may need to have some changes made to their schedule so that concussion symptoms do not get worse. If a particular activity makes symptoms worse, then the athlete should stop that activity and rest until symptoms get better. To make sure that the athlete can get back to school without problems, it is important that the healthcare provider, parents, caregivers and teachers talk to each other so that everyone knows what the plan is for the athlete to go back to school.

**Note: If mental activity does not cause any symptoms, the athlete may be able to skip step 2 and return to school part-time before doing school activities at home first.**

Mental Activity	Activity at each step	Goal of each step
1. Daily activities that do not give the athlete symptoms	Typical activities that the athlete does during the day as long as they do not increase symptoms (e.g. reading, texting, screen time). Start with 5-15 minutes at a time and gradually build up.	Gradual return to typical activities.
2. School activities	Homework, reading or other cognitive activities outside of the classroom.	Increase tolerance to cognitive work.
3. Return to school part-time	Gradual introduction of school-work. May need to start with a partial school day or with increased breaks during the day.	Increase academic activities.
4. Return to school full-time	Gradually progress school activities until a full day can be tolerated.	Return to full academic activities and catch up on missed work.

If the athlete continues to have symptoms with mental activity, some other accommodations that can help with return to school may include:

- Starting school later, only going for half days, or going only to certain classes
- Taking lots of breaks during class, homework, tests
- More time to finish assignments/tests
- No more than one exam/day
- Quiet room to finish assignments/tests
- Shorter assignments
- Not going to noisy areas like the cafeteria, assembly halls, sporting events, music class, shop class, etc.
- Repetition/memory cues
- Use of a student helper/tutor
- Reassurance from teachers that the child will be supported while getting better

**The athlete should not go back to sports until they are back to school/learning, without symptoms getting significantly worse and no longer needing any changes to their schedule.**

# Child SCAT5<sup>®</sup>

SPORT CONCUSSION ASSESSMENT TOOL  
FOR CHILDREN AGES 5 TO 12 YEARS  
FOR USE BY MEDICAL PROFESSIONALS ONLY

supported by



FIFA



## Patient details

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

Address: \_\_\_\_\_

ID number: \_\_\_\_\_

Examiner: \_\_\_\_\_

Date of Injury: \_\_\_\_\_ Time: \_\_\_\_\_

## WHAT IS THE CHILD SCAT5?

The Child SCAT5 is a standardized tool for evaluating concussions designed for use by physicians and licensed healthcare professionals<sup>1</sup>.

If you are not a physician or licensed healthcare professional, please use the Concussion Recognition Tool 5 (CRT5). The Child SCAT5 is to be used for evaluating Children aged 5 to 12 years. For athletes aged 13 years and older, please use the SCAT5.

Preseason Child SCAT5 baseline testing can be useful for interpreting post-injury test scores, but not required for that purpose. Detailed instructions for use of the Child SCAT5 are provided on page 7. Please read through these instructions carefully before testing the athlete. Brief verbal instructions for each test are given in *italics*. The only equipment required for the tester is a watch or timer.

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## Recognise and Remove

A head impact by either a direct blow or indirect transmission of force can be associated with a serious and potentially fatal brain injury. If there are significant concerns, including any of the red flags listed in Box 1, then activation of emergency procedures and urgent transport to the nearest hospital should be arranged.

## Key points

- Any athlete with suspected concussion should be REMOVED FROM PLAY, medically assessed and monitored for deterioration. No athlete diagnosed with concussion should be returned to play on the day of injury.
- If the child is suspected of having a concussion and medical personnel are not immediately available, the child should be referred to a medical facility for urgent assessment.
- Concussion signs and symptoms evolve over time and it is important to consider repeat evaluation in the assessment of concussion.
- The diagnosis of a concussion is a clinical judgment, made by a medical professional. The Child SCAT5 should NOT be used by itself to make, or exclude, the diagnosis of concussion. An athlete may have a concussion even if their Child SCAT5 is "normal".

## Remember:

- The basic principles of first aid (danger, response, airway, breathing, circulation) should be followed.
- Do not attempt to move the athlete (other than that required for airway management) unless trained to do so.
- Assessment for a spinal cord injury is a critical part of the initial on-field assessment.
- Do not remove a helmet or any other equipment unless trained to do so safely.

## Appendix no 3

### CONCUSSION FRAMEWORK

Head injury/concussion framework	How is this currently managed in tournament?	Is this an existing or proposed policy/rule?
Preventative rules	Excessive contact rule in place already	Existing policy/rule
Enforcement of rules	Down to umpires in individual tournaments to interpret current excessive contact rule	Existing policy/rule
Recognition of concussion rule	Based on individual/tournament decision making - New head injury/concussion policy needed	Proposed new policy/rule
Removal from tournament rule	Based on individual/tournament decision making - New head injury/concussion policy needed	Proposed new policy/rule
Graduated return to contact sport rule	Based on individual/tournament decision making - New head injury/concussion policy needed	Proposed new policy/rule
Education	Education needed at all levels of Taekwon-Do on prevention/recognition/removal/return	Proposed new education program
Head injury surveillance and data analysis	Future research project	Proposed future research