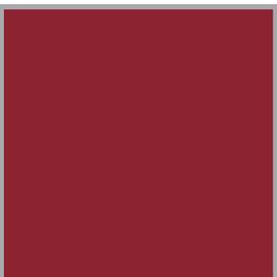


Football Resources



MSHSAA

Missouri State High School Activities Association



Missouri State High School Activities Association

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TO: Head Football Coaches and Athletic Administrators
FROM: Greg Stahl, MSHSAA Assistant Executive Director
SUBJECT: Football Fall Packet

I hope you have had a relaxing and enjoyable summer vacation and that you are ready to start the new school year. In this booklet please find important and necessary materials for the ensuing football season.

Please Note:

- High School football teams may start practice on **Monday, July 31, 2017.**
- Junior High football teams may start practice on **Monday, August 14, 2017.**
- This is the second year of the two-year cycle for district assignments.
- Beginning with 2018-19 school year, the MSHSAA will begin using 1 year cycles that results in classification breaks and district assignments being coordinated every year.
- This is the sixth year of the new football playoff format. Each team can track their regular season progress and standings weekly on the MSHSAA website from your school's football schedule page at (www.mshsaa.org).
- Please read the Football Manual found on the MSHSAA website (www.mshsaa.org).

If I can be of any additional assistance, please don't hesitate to email or call. I look forward to working with you and your students this school year.

Best wishes for an enjoyable school year and good luck during the 2017 football season!

Greg Stahl,
MSHSAA Assistant Executive Director

GS/kc

“The MSHSAA promotes the value of participation, sportsmanship, team play and personal excellence to develop citizens who make positive contributions to their community and support the democratic principles of our state and nation.”

2017 FOOTBALL SEASON REGULATIONS

Rules in this section are specific for football. Refer to MSHSAA Constitution, By-laws and Board of Directors Policies for regulations related to age, residence, scholarship, amateur status, etc.

1. PRESEASON

- a. An organizational meeting may be conducted prior to the season opening provided no instruction or practice is included.
- b. Issuing of equipment may take place prior to the earliest day for practice (**July 31, 2017**).

2. LENGTH OF SEASON

- a. High School - the earliest day practice may begin is **Monday, July 31, 2017**. The season ends on **Saturday, November 25, 2017**.
- b. Junior High School sports seasons shall be twelve consecutive calendar weeks in length beginning with the first organized practice with any part of a sports squad and ending with the last interscholastic contest. The earliest day practice may begin for any middle school sport is **Monday, August 14, 2017**.
- c. The sports season for the seventh and eighth grade teams may be scheduled at any time during the period beginning with **Monday August 14, 2017**, and ending with the last day of school in the spring.

3. FALL SEASON PRACTICE GUIDELINES

Intent:

To encourage state high school athletic associations to recommend a pre-season acclimatization and recovery model for all sports that enhances student-athlete well-being.

Rationale:

Research has supported the findings, which indicate an increase in heat-related injuries resulting from inadequate pre-season acclimatization practices (1-12). Similarly, the incidence in stress-related injuries (i.e., Stress fractures, tendonitis) has been found to be directly proportional to the work-rest ratio of the athlete (6, 7, 13 – 15). For these reasons, it is the recommendation of the National Federation of High School Association's (NFHS) Sports Medicine Advisory Committee and the National Athletic Trainers' Association's (NATA) Secondary School Committee that all fall sports use acclimatization and recovery principles to develop their fall pre-season practice schedules for the purpose of enhancing the student-athlete well-being. The primary focus of the pre-season period should be to provide an adjustment period to the intensity and duration of exercise and environmental conditions. The guidelines outline a fourteen-day period based on the science of acclimatization that also differentiates sports with equipment due to the unique stress on the body's heat dissipation capabilities. The foundation for this model was based upon the NCAA version adopted by the NCAA Committee on Competitive Safeguards and Medical Aspects of Sports.

4. SUMMARY OF THE 16-DAY ACCLIMATIZATION PERIOD

Days 1-5

1. Days 1 through 5 of the acclimatization period consist of the first 5 days of formal practice. During this time, athletes are not allowed to participate in more than 1 practice per day.
2. If a practice is interrupted by inclement weather or heat restrictions, the practice may recommence once conditions are deemed safe. Total practice time should not exceed 3 hours in any 1 day.
3. A 1-hour maximum walk-through is permitted during Days 1-5 of the acclimatization period. A 1-hour recovery period is required between the practice and walk-through (or vice-versa).
4. During Days 1-2 of the acclimatization period in sports requiring helmets or shoulder pads, a helmet is the only protective equipment permitted (goalies, as in the case of field hockey and related sports, may not wear full protective gear or perform activities that would require protective equipment. During Days 3-5, only helmets and shoulder pads may be worn. Beginning on Day 6, all protective equipment may be worn and full contact may begin.
 - a. Football Only: On Days 3-5 contact with blocking sleds and tackling dummies may be initiated.
 - b. Full-Contact Sports: 100% live contact drills may begin no earlier than Day 6.

Days 6-16:

1. Beginning no earlier than Day 6 and continuing through Day 14, double-practice days must be followed by a single-practice day. On single-practice days, 1 walk-through is permitted, separated from the practice by at least 1 hour continuous rest. When a double practice day is followed by a rest day, another double-practice day is permitted after the rest day.
2. On a double-practice day neither practice may exceed 3 hours in duration nor may student-athletes participate in more than 5 total hours of practice. Warm-up, stretching, cool-down, walk-through, conditioning, and weight-room activities must be included as part of the total practice time. The 2 practices must be separated by at least 3 continuous hours in a cool environment.
3. Because the risk of exertional heat illnesses during the preseason heat-acclimatization period is high, it is recommended that an athletic trainer be on site before, during and after all practices. This is not required.

16 DAY ACCLIMATIZATION PERIOD – FOOTBALL SPECIFIC GUIDELINES

Day	Level of Contact	Heat Acclimatization Practice Plan	Sports Equipment/Helmets/Pads
1	Air	One Practice per day (3 hours Total) 1 hour walkthrough after 1 hour of rest	helmet only spandex girdle or pants without pads allowed
2	Air	One Practice per day (3 hours Total) 1 hour walkthrough after 1 hour of rest	helmet only spandex girdle or pants without pads allowed
3	Air/Bag/Control	One Practice per day (3 hours Total) 1 hour walkthrough after 1 hour of rest	helmet shoulder pads blocking sleds tackling dummies only spandex girdle or pants without pads allowed

4	Air/Bag/Control	One Practice per day (3 hours Total) 1 hour walkthrough after 1 hour of rest	helmet shoulder pads blocking sleds tackling dummies only spandex girdle or pants without pads allowed
5	Air/Bag/Control	One Practice per day (3 hours Total) 1 hour walkthrough after 1 hour of rest	helmet shoulder pads blocking sleds tackling dummies only spandex girdle or pants without pads allowed
6-16	Air/Bag/Control Thud/Live	<ul style="list-style-type: none"> • Alternate double practice days with a single practice day or a rest day. • Single Day - 1 walk through is permitted, separated from the practice by at least 1 hour continuous rest. When a double practice day is followed by a rest day, another double-practice day is permitted after the rest day. • Double Day - 3 hour max per practice. 5 hour max total with 3 hour minimum rest between the 2 single practice day - 3 hour max; Warm-up, stretching, cool-down, walk-through, conditioning, and weight-room activities must be included as part of the total practice time. • 1 hour walkthrough after 1 hour rest 	<p>all equipment full contact</p> <p>spandex girdle allowed WITH Football pants and required pads included.</p>

Definitions: Air, Bag, Control, Thud and Live are levels of contact as defined by USA Football. For detailed definitions of these levels of contact use the following internet link.

<https://usafootball.com/health-safety/levels-of-contact>

Special Notes:

- During the preseason heat acclimatization period, if practice occurs on six consecutive days, participants should have one day of complete rest (no conditioning, walk-throughs, practices, etc.) Therefore, 16 days are needed to complete the 14-practice requirement.
- On-site Athletic Trainer for the heat acclimatization period (days 1-16) if possible, but not required.
- In football the preseason scrimmage is a practice and the time spent for this scrimmage counts towards the total hours of practice in a day.
- Football will have a 5 day acclimatization period before full contact with pads during the summer.
- Days 1-5: Spandex Girdle may be worn but not covered with football pants.

Section 1: School Essential By-Laws:

1.7 Heat Acclimatization

1.7.1 Heat Acclimatization Period: For the health and safety of participants, member schools shall follow the Heat Acclimatization Schedule as described below and as summarized in Diagram 1.7 (1) and (2) for all fall sports. The Heat Acclimatization Schedule sets forth a progressive system of early practices along with periods of rest. The goal of the Heat Acclimatization Period is to increase exercise heat tolerance and enhance the ability to

exercise safely and effectively in warm and hot conditions. This period shall begin on the first day of practice or conditioning.

- 1.7.2 **Heat Acclimatization Definitions:** Some definitions of terms used in the Heat Acclimatization system can be found in other sections of the MSHSAA Handbook, and are listed below:
- a. A “day” is defined as a calendar day (12:00 a.m. through 11:59 p.m.).
 - b. **Recovery Period:** A recovery period is defined as the time between the end of one practice or walk-through and the beginning of the next practice or walk-through. During this time, students should rest in a cool environment, with no sport -related or conditioning-related activity permitted (e.g., speed or agility drills, strength training, conditioning, or walk-through). Treatment with the athletic trainer is permissible.
 - c. **Fall Sports:**
 1. **Definition of Practice:** See By-Law 3.16.1
 2. **Definition of Conditioning Practice:** See By-Law 3.16.2
 3. **Definition of Walk-Through:** See By-Law 3.16.3
- 1.7.3 **Limits and Requirements within Heat Acclimatization Period:**
- a. **First Five Days:** Only one practice may be held on each of the first five days of the Heat Acclimatization Period. Further, one walk-through may be held after a rest period of one or more hours.
 - b. **Practice Duration:** Each individual practice shall last no more than three hours. Warm-up, stretching, and cool-down activities are included as part of the three-hour practice time. Regardless of ambient temperature conditions, all conditioning and weight-room activities must be considered part of practice. Note: Days on which athletes do not practice due to a scheduled rest day, injury, or illness do not count toward the heat-acclimatization period, nor do they count as a “conditioning practice.”
 - c. **Walk-Through Limits:** A walk-through is not part of the **three-hour** practice period, can last no more than **one hour** per day, and does not include conditioning or weight-room activities.
 - d. **Double Practice Days:** Two double practice days may not be held back-to-back; a double practice day must alternate with a single practice day or a rest day. On a double practice day, a single practice may not exceed three hours, and total hours of practice may not exceed five hours. A minimum of one hour of rest must be provided between the two practices.
 - e. **Required Rest Day:** If practice occurs on six consecutive days, participants shall have one day of complete rest (no conditioning, no practice, and no walk-throughs). Therefore, sixteen dates are required to complete the fourteen-day Heat Acclimatization Period.

Section 3: Athletic Activity By-Laws:

- 3.16.1 **Practice:** Any attempt of a coach at a given school to provide instruction in any phase of a game or athletic activity to any team or part of a team at that school or to have any team or part of a team engage in drills under the supervision of a coach, or from directions provided by the coach, involving what has already been taught. Try-outs, so-called “skull sessions,” “chalk talks,” “walk-throughs,” etc., are considered practices but do not qualify as “conditioning practices” (See 3.16.2). General Informational Meetings, where no attempt is made to teach any phase of a game or activity, are permitted before the first allowable practice date of the specific sport season. Except as provided for in By-Laws 3.5.3, 3.10.3, 1.4.1, and 1.4.2 a junior high or high school student shall be permitted to participate in school practices only with teams of the school where he/she is properly enrolled.
- 3.16.2 **Conditioning Practice:** Any attempt by the coach to engage the student in specific physical activity, drills, and/or instruction involving physical activity designed to elevate the student’s level of physical condition for a specific sport. (See also By-Law 3.9, Conditioning Requirements)

- 3.16.3 **Walk-through:** A walk-through is defined as a teaching opportunity with the athletes not wearing protective equipment (e.g., helmets, shoulder pads, catcher's gear, shin guards) or using other sport-related equipment (e.g., footballs, blocking sleds, pitching machines, soccer balls).

5. PRESEASON INTER-SCHOOL SCRIMMAGE

- a. Senior high schools only may participate in the preseason inter-school scrimmage.
- b. The preseason inter-school scrimmage shall consist of three or four schools.
- c. The preseason inter-school scrimmage must be under contract with participating schools.
- d. The preseason inter-school scrimmage shall be officiated by MSHSAA registered officials.
- e. Each participant shall have at least 9 individual days of physical conditioning practice prior to participating in the preseason inter-school scrimmage. The 9th day of conditioning practice must occur on a day preceding the day of the event.
- f. No kicking game shall be permitted.
- g. When there are four schools participating, a maximum of 3 quarters per team with a maximum of 12 offensive plays per quarter shall be allowed. When there are three schools participating, a maximum of 2 quarters per team with a maximum of 18 offensive plays per quarter shall be allowed.
- h. All game rules shall apply with the exception that coaches may be on the field to provide instruction.
- i. The scrimmage may only be conducted on the Friday or Saturday of Week 6 (August 11 or August 12).
- j. The host school shall determine the admission charge.

6. DATE OF FIRST GAME

The first game may not be played before **Friday, August 18, 2017**.

7. MAXIMUM ALLOWED GAMES

- a. The maximum number of games is 10 for senior high schools.
- b. The maximum number of games is 6 for grades 7 and 8.
- c. The MSHSAA first round district game is part of the maximum allowed games.
- d. The MSHSAA district semi-final, district final, quarterfinal, semifinal and final games are not part of the maximum allowed games.

8. INDIVIDUAL PARTICIPATION LIMITATIONS

- a. No player may play in more than four quarters on one calendar date.
- b. **No player may play in more than six quarters in a football week. Note: For the purposes of tracking player quarters, a football week is defined as beginning on a Friday and ending on the following Thursday.**
- c. No player may play in a total number of quarters for the season that exceeds six times the number of games played by the higher team on which he plays.
- d. Each school shall be responsible for keeping a record of the participation of players of both teams.
- e. MSHSAA By-Law 3.23.1 was amended in April 2017 by a vote of the member schools. (See Additional document included in the Fall sports mailing).

9. FLAGRANT OR UNSPORTSMANLIKE CONDUCT

- a. The Board of Directors is vested with the power to suspend schools from membership for the unsportsmanlike conduct of teams, coaches, students or fans.

- b. Each school is responsible for the conduct of its teams, coaches, students and fans at games both at home and away.
- c. The Board may delegate to the Executive Director power to take immediate action when a situation demands such.
- d. The party or parties concerned shall have the privilege of requesting a hearing before the Board of Directors at its next regularly scheduled meeting for a review of the case and the action taken by the MSHSAA Office.
- e. The Board of Directors may, at its discretion, substitute a fine not to exceed the sum of \$25 for each offense in lieu of suspension from the Association or may take any action that it deems advisable, that does not exceed the maximum penalty of 365 days suspension from the association.
- f. A player who is ejected from a contest for unsportsmanlike conduct shall at a minimum be prohibited from playing in the next interscholastic contest at that same level.
- g. A coach who is ejected during a contest for unsportsmanlike conduct shall at a minimum be prohibited from coaching and attending the next interscholastic contest for that team.
Furthermore, it is mandatory that the coach complete the NFHS Online Sportsmanship course prior to returning to coaching a contest/game.
- h. A player or coach who is ejected from the Preseason Inter-School Scrimmage for unsportsmanlike conduct shall at a minimum be prohibited from playing or coaching in the remainder of the Preseason Inter-School Scrimmage and in the next interscholastic varsity contest.

10. PROHIBITION OF PRACTICE AT TOURNAMENT SITE

- a. Practice at districts through semifinals contests.
 - 1. There shall be no practice held on the field except for the home team on their home field unless the game is moved to a neutral site with an artificial surface.
 - 2. In the event that the game is moved to a neutral site with an artificial surface, if the field is available to both teams, one practice would be permitted for each team.
 - 3. Warm-up prior to game time shall be limited to a maximum of 75 minutes.
- b. Practice at state championships site.
 - 1. There shall be no practice held on the field.
 - 2. Warm-up prior to game time shall be limited to a maximum of one hour (and a minimum of 25 minutes) at the state championship venue.

11. CONTEST CONTROL

- a. All schools are responsible before, during and after a contest for the proper conduct of their coaches, athletes, students and other spectators.
- b. Schools are expected to prohibit and/or eliminate pranks, mischief or any other activity involving destruction, theft, etc., of athletic facilities, equipment and material.
- c. Schools will be held responsible for seeing that no damage to property, tearing down of goal posts, etc., is done by their students or fans.
- d. Students engaging in vandalism will be considered ineligible.
- e. School administrators are to be present, both home and away, and responsible for supervising and controlling coaches, players, cheerleaders, band members, other student groups, and all of their fans; and to take steps to prevent vandalism, violence and other acts of unsportsmanlike conduct.
- f. There have been instances where fans have been permitted to gather and stand along the sidelines or end lines of playing fields and a number of instances have been reported in which fans have approached the sidelines near the end of the game.

1. Generally, this is for the purpose of rushing onto the field to express jubilation over winning.
2. In other instances, fans have cast disparaging remarks toward opposing players and officials.
3. In either case, it creates a situation conducive to crowd control problems.
4. All schools should take steps to educate their students and fans to refrain from moving onto the court or playing field following games.
5. The practice of entering these areas following games does not contribute anything toward the most worthwhile objectives of interscholastic competition and can contribute toward misconduct.
6. Under these conditions, the Board of Directors has adopted a policy authorizing and urging game officials to stop the game when this occurs, send the teams to the benches, and requests the host school administration to have the fans return to their seats or leave the field before play is continued.
7. The game shall not continue until the fans comply.
8. The primary responsibility for compliance with the game officials request falls on the host school, but the visiting school is also responsible for seeing that their fans remain in their seats.

SUGGESTED GUIDELINES FOR MANAGEMENT OF HEAD TRAUMA IN SPORTS

Head trauma is a common problem in sports that has the potential for serious complications if not managed correctly. Even what appears to be a “minor ding or bell ringer” without loss of consciousness has a real risk of catastrophic results in a youngster who is returned to action too soon. The medical literature and lay press are reporting instances of death from “second impact syndrome” even after mild concussions. This increased vulnerability of the brain to concussions close together and the cumulative effects of multiple concussions are becoming known risks that need to be addressed.

At many athletic contests across the country, there is a lack of trained and knowledgeable individuals making the decision to return concussed athletes to the game. Frequently, there is undo pressure from various sources (parents, player, and coach) to return a valuable athlete to action ASAP. In addition, there is often unwillingness by the athlete who wants to play to report headaches and other findings that she/he knows will prevent his/her return to play. Research is now revealing some fairly objective, easy-to-use tests that can easily be performed on the sidelines which appear to identify subtle residual deficits that may not be obvious from the traditional evaluation. Although having base line data on the athletes at the time of the pre-participation examination enhances the usefulness of these tests, recent studies suggest the ability to differentiate concussed from non-concussed athletes with some of these instruments. These identifiable deficits frequently persist after the obvious signs of concussion are gone and appear to have relevance to whether an athlete can return to the game in relative safety. The significance of these deficits is still under study and the evaluation instruments represent a work in progress. However, even in their present state of evolution, their effectiveness, validity, and ease of utilization make them a much preferable way to assess a youngster after a concussion than the hit-and-miss methods now being utilized across the country. Again, these should not be utilized exclusively without consideration of the severity and nature of the injury, the interval since the last head injury, the level of play and the clinical judgment of the examiner depending on his or her training.

The National Federation of State School Associations recommends that State Associations distribute this information to the athletic directors in all their member schools so that persons making sideline decisions to allow an athlete to return to play can benefit from the latest knowledge on how to assess concussed athletes for warning signals that might suggest they not return to the game. In addition to the usual observations as to whether the athlete “seems OK,” some assessment of orientation, memory, and coordination at rest and after physical exertion is important to have a comprehensive knowledge of the athlete’s mental status.

We have outlined some guidelines below that may be helpful in establishing a protocol at your institutions. Please bear in mind these are general guidelines and must not be used in place of the central role that physicians and certified athletic trainers must play in protecting the health and safety of student athletes.

CONCUSSION EDUCATION AND MANAGEMENT PROTOCOL

Education

Concussions are common in sports. The Missouri State High School Activities Association (MSHSAA) believes that education of coaches, officials, athletes, and their parents or guardians are key to safely returning a student athlete to play. Appropriate immediate care after a suspected concussion, and follow up incorporating a multi-disciplinary team that includes the coach, parent or guardian, athlete’s physician, team physician and athletic trainer (if available), and school representatives, also are important for the proper management of a sport-related concussion.

Each school district will receive educational materials for coaches, athletes, parents, and school officials, required forms for student athlete participation and parent/guardian consent, and recommended medical clearance forms for return to play.

Annually, MSHSAA member school districts will ensure that every coach, student athlete, and parents or guardians of a student athlete completes a concussion and head injury information sheet and returns it to the school district prior to the student athlete’s participation in practice or competition. Officials will receive training from their parent organization. Each official’s organization will require annual concussion training and maintain a signed head injury information sheet for each official.

Recognition and Evaluation of the Athlete with a Concussion

1. Recognition of the signs and symptoms of a concussion is important. Every member of the team-athlete, teammates, coaches, parents or guardians, officials, athletic trainers, and team physicians have a duty to report a suspected concussion. Not all school districts have medical personnel available to cover every practice and competition; therefore, the coach is the person in the best position to protect the player and must be aware that not all student athletes will be forthcoming about their injury.
2. An official shall not be responsible for making the diagnosis of a concussion. The official can assist coaches and medical staff by recognizing signs and symptoms of a concussion and informing the coach and medical staff of their concerns.
3. The coach, ATC, or physician on site should evaluate the athlete in a systemic fashion :
 - a. Assess for airway, breathing, and circulation (basic CPR assessment).
 - b. Assess for concussion.
 - i. Any unconscious athlete should be assumed to have a severe head and/or neck injury and should have their cervical spine immobilized until a determination can be made that the cervical spine has not been injured. If no medical professional can make the assessment, the athlete should be transported to an appropriate emergency care facility.
 - ii. A conscious athlete with no neck pain can be further evaluated on the sideline.
4. An athlete experiencing ANY of the signs/symptoms of a concussion should be immediately removed from play. Signs/Symptoms of a concussion include:

<u>PHYSICAL</u>	<u>COGNITIVE</u>	<u>EMOTIONAL</u>
Headache	Feeling mentally "foggy"	Irritability
Nausea/Vomiting	Feeling slowed down	Sadness
Dazed/Stunned	Difficulty concentrating	More emotional
Balance problems	Difficulty remembering	Nervousness
Visual problems	Forgetful of recent information	
Fatigue	Confused about recent events	
Sensitivity to light	Answers questions slowly	
Sensitivity to noise	Repeats questions	

5. Evaluation

- a. Following any first aid management, the medical team, or coach in the absence of medical personnel, should assess the athlete to determine the presence or absence of a concussion. The SCAT (Sideline Concussion Assessment Tool) and SCAT2 are effective assessment tools that are readily available and can assist with the assessment.
- b. The athlete should be monitored for worsening or change in signs and symptoms over the next 24 hours. Instructions should be given to the parent or guardian as to signs and symptoms that may require further or more emergent evaluation.

6. Management of a Concussion and Return to Play

- a. An athlete determined to have a concussion or have concussion-like symptoms will be removed from practice or competition and is not allowed to return to practice or competition that same day.
- b. If an athlete displays concussion-like signs or symptoms, the athlete should be assumed to have a concussion until further medical evaluation can occur. "WHEN IN DOUBT, SIT THEM OUT!"
- c. Written clearance from a physician (MD or DO), Advanced Nurse Practitioner in written collaborative practice with a physician, Certified Physician Assistant in written collaborative practice with a physician, or Certified Athletic Trainer in written supervision of a physician, must be provided prior to return to play.
- d. Following a concussion, the athlete should have both physical and cognitive rest until symptoms have resolved.
- e. An athlete must be asymptomatic at rest and with exertion prior to return to play
- f. A graduated return to play protocol has been outlined by the Third International Concussion in Sport Group Statement (2008, Zurich), is recommended by the NFHS (nfhs.org), and may be used to guide return to play following medical clearance.

PLAYER LIMITATIONS AND QUARTER COUNTING

A Change to MSHSAA By-Law 3.23.1 was submitted by the Sports Medicine Advisory Committee and the Football Advisory Committee relative to player limitations for the total number of “quarters” per player that can be participated in during a defined football week. **This change was voted on and passed by member schools in April – 2017 and becomes mandatory beginning with the 2017 Football Season.**

3.23 FOOTBALL REGULATIONS

3.23.1 Individual Player Limits:

- a. **Daily**: No player may play in more than four quarters on one calendar date.
- b. **Weekly: No player may play in more than six quarters in a football week. Note: For the purposes of tracking player quarters, a football week is defined as beginning on a Friday and ending on the following Thursday.**
- c. **Season**: No player may play in a total number of quarters for the season that exceeds six times the number of games played by the higher team on which the student plays.
- d. **Kicking Downs**: Participation in kicking downs only (downs in which one team initially lines up in either a scrimmage kick or a free kick formation as per NFHS Rules) during a game would count as a maximum of one quarter of participation.
- e. **Other Downs**: Participation in downs other than kicking downs would count as one quarter of participation for each quarter the player participates up to a maximum of four quarters per game and six quarters in a football week.
- f. **Tracking**: Each school shall be responsible for keeping a record of the participation of players of both teams utilizing the MSHSAA standardized “Football Player Participation Form.”

The official “Football Quarters – MSHSAA Participation Record” form must be used for tracking quarters. A copy of this form is provided in the fall mailing for head football coaches.

- One sheet should be filled out for each game played at all levels.
- There is enough room on one sheet for 45 players.
- If you play more than 45 players in any particular game fill out a second sheet for that game.
- You may copy the enclosed sheet as often as necessary.
- Only the enclosed sheet will be accepted if a question is raised as to how many quarters a player has played.
- A sheet for each game should be filled out after the completion of the game and prior to the next scheduled game.

DEFINITION OF KICKING DOWN: Any down in which a team initially lines up in a free kick or scrimmage kick formation as defined by NFHS Rules.

- Example 1: A player participates as a member of the kickoff team in all four quarters but does not participate in any other downs. In this situation the quarters of participation equal 1.
- Example 2: A player participates as a wide receiver in the 2nd and 3rd quarters and is the punter in all 4 quarters. In this situation the quarters of participation equal 3.

Athletic Mouthguards: Know the Differences! Are You Getting the Anticipated and Expected Protection?

by

Ray R. Padilla, DDS Academy for Sports Dentistry UCLA School of Dentistry

Coaches and trainers have all heard, "My mouthguard is uncomfortable. I can't talk clearly with it. It makes me gag. Why should I wear it?" Many football players experience discomfort, difficulty in breathing, problems with speech, and lack of retention with their mouthguards. It has gotten to be such a problem that many professional football players do not utilize any type of mouthguard. In fact, at the collegiate level where mouthguards are mandatory equipment, many of the athletes do not wear mouthguards. On any given Saturday, it is easy to spot which athletes, especially quarterbacks, are not using mouthguards. And those that are wearing mouthguards are left with a false sense of security if they are utilizing one that does not fit properly. The resultant injury can come at a high cost when it comes to dental and medical treatment, and can be career and life threatening if concussions are sustained.

At impact, when protection is most needed, there is none. Basically, store-bought mouthguards generally do not fit the athlete as accurately as professionally made custom made mouthguards. A properly fitted mouthguard would not dislodge at impact. Custom made mouthguards made by a qualified health professional do fit the athlete accurately. There are four types of mouthguards; types I, II, III, and IV. Type I is the store bought over-the-counter STOCK mouthguard. They are removed from the bag and placed directly in the mouth. There is no attempt at fit. When push comes to shove, they offer very little security. They are the least expensive and offer the least protection. They are kept in the mouth by constantly biting down and putting pressure against the teeth. Also available over-the-counter is the Type II-BOIL & BITE Mouthguard. This is the most common type of mouthguard worn today. However, they come in limited sizes and with little attempt at proper fit. The athlete forms the mouthguard by placing it in boiling water and molds the shape with tongue, lip, and finger pressure. These distort easily as warm body temperatures are sufficient enough to warp and deform the mouthguard. Also, during formation, the athlete is asked to bite down creating such a thin surface that there is no separation between the upper and lower jaws to prevent a possible concussion. Again, a false sense of security.

In 1993, a paper by Joon Park, Department of Biomedical engineering at the University of Iowa College of Dentistry commented, "Unless dramatic improvements are made in these products, they should not be promoted to the customers as they are now."

We often see players trim these type II mouthguards off at the back so they cover only the anterior teeth. In virtually every case, they are cutting these mouthguards because they do not fit and are uncomfortable. Once you shear off the posterior segment of the mouthguard, you are removing the protective properties for concussion. The mouthguard needs coverage to at least the first molar, at a specific thickness of at least 3mm, to be preventive.

The third variety is the Type III-Vacuum Custom Made Mouthguard built by the team dentist or trainer from a model or cast of the athlete's mouth. An exact impression is taken for a plaster or stone model to fabricate a mouthguard with a vacuum machine. Until recently, this was believed to be the best mouthguard available. The medical/dental literature is now describing that over time these mouthguards can undergo memory change, so the mouthguard which fits at the initial insertion, after several weeks of performing in the athletes mouth, becomes loose, thins out and perforates as the athlete chews through it. There is no way to insure a proper thickness. In the past, when making these Type III mouthguards, health care providers had to remake them every few weeks to insure proper protection for athletes.

Now, with the Type IV variety, the mouthguards last the entire season. Today's state of the art mouthguard is believed to be the Type IV Pressure Laminated Custom Made Mouthguard. It is fabricated by the team dentist or trainer from several layers of mouthguard material in a special heat/pressure lamination machine. Due to the method of production, the material maintains its fit and

protective thickness over prolonged periods of time. The true test of a comfortable protective mouthguard is whether or not it can be worn without using a strap. Does it stay in the mouth comfortably without hindrance in speech and breathing? Can it be worn by the quarterback comfortably without impeding performance?

It is essential that mouthguards maintain a perfect fit and sufficient thickness for the prevention of concussion. The medical/dental literature has shown that the number of concussions caused by a blow to the chin can be dramatically reduced when a proper mouthguard is worn. During impact to the chin, in most instances, the temporal bone is violated as it houses nerves, blood supply, and auditory and balance mechanisms existing the base of the brain.

J.M. Stenger, in his classic paper published in the Journal of the American Dental Association as far back as 1964, recognized that dental/facial injuries, concussions and head and neck injuries were dramatically reduced when mouthguards were worn by the Notre Dame football team. Other well-established papers by William Haunts and P.J. Chapman, reported that properly fabricated custom mouthguards reduced the rate of concussion as well as dental and mandibular injuries. Chapman further stated, "The use of mouthguards should be encouraged in all contact sports as the most important value of the mouthguard is the concussion saving effect following impact to the mandible. This fact alone should make the wearing of mouthguards compulsory in all contact sports". It has also been demonstrated in the literature that both intracranial pressure and bone deformation were reduced with proper mouth protectors.

When the Type IV Heat Pressure Laminated Custom Mouthguards are made by the dentist or trainer, all posterior teeth can be comfortably covered with a predicted and consistent prescribed thickness to properly separate the teeth from blows to the jaw. In turn, the force of impact can be absorbed and equally distributed throughout the mouthguard. With proper thickness in the posterior segment of the mouthguard, the mandible (lower jaw bone) and maxilla (upper jaw bone) are separated and the force is not transmitted to the base of the brain. In football, when mouthguards are not worn, the mandible is placed in the most vulnerable position for injury and concussion, upwards and back into the fossa and base of the skull due to the tight strap that keeps the helmet on. It is no coincidence that the player that least wears a mouthguard (quarterback) is the athlete that sustains the most concussions from blows to the chin. It is also reported that once an individual has endured a first concussion he is four times more likely to experience another. Mouthguards can be properly made for speech and comfort and still fulfill the important job of concussion prevention.

The benefits of the new Type IV Pressure Laminated Mouthguard will be publicized more frequently in the near future. A mouthguard that fits properly, is comfortable, and is worn will be protective and reduce the number of injuries and concussions now evident at all levels of football. In this litigious society, it is important that the athlete knows all the options for injury prevention and makes the educated decision on what he/she wants to wear. One would not think of wearing ill-fitting helmets or other protective equipment. They why are athletes wearing ill-fitting mouthguards? Health professionals, coaches, and athletes all understand the value and need for measures to prevent injuries and maintain a healthy quality of life achieved by not bearing life debilitating injuries.

Concussive pain and blackouts don't necessarily end with retirement. One need only to observe athletes such as Muhammed Ali, Jerry Quarry, Al Toon, Merrill Hodge and others to realize the possibility that repeated concussions can lead to permanent brain damage. Adding several years to a player's career can be beneficial both financially and professionally and it is important to maintain the athlete's quality of life well past retirement.

Also, it is essential to properly treat athletes who have a history of concussion and do all that is possible to help prevent further episodes. Dentally, once teeth are lost they do not heal or grow back. They are gone forever and the athlete is condemned to being a dental cripple for the rest of his/her life. By acknowledging that there are substantial differences in mouthguards, we can seriously look at providing a much higher level of protection for athletes.

NOTE: The above is a reprint, as it appeared, in the American Football Quarterly, Volume 2, Fourth Quarter 1996.



APPROPRIATE CARE OF THE SPINE INJURED ATHLETE

Updated from 1998 document

Background: In 1998 the National Athletic Trainers' Association served as the host organization for an interassociation task force to develop guidelines for the care of the spine injured athlete. This 2015 document is an executive summary update of that 1998 document providing revised recommendations and key insights for the management of the cervical spine injured athlete. Recently, members of the original task force and additional spine trauma researchers discussed many changes in the current literature regarding pre-hospital treatment protocols for the cervical spine injured athlete-patient. These changes were the impetus for the development of the second inter-association task force.

Key Points:

- Traumatic spinal cord injury (SCI) is a devastating condition that merits concerted focus due to its high rates of morbidity and mortality.
- Approximately 12,500 new cases of SCI are reported in the United States each year. Nine percent of these cases are due to participation in sports and recreational activities.
- The athlete-patient with a suspected SCI presents challenges for medical providers that are not common with the general population. The best example for this comes with athletes in equipment-intensive sports such as football, ice hockey and lacrosse where the equipment worn for protective purposes creates a treatment barrier for basic or advanced life support skills requiring access to the airway and chest.
- The sports medicine team must work together as an efficient unit in order to accomplish its goals. In an emergency situation, the team concept becomes even more critical, because miscommunication may lead to errors with potentially catastrophic repercussions.

Recommendation 1: It is essential that each athletic program have an Emergency Action Plan (EAP) developed in conjunction with local EMS.

- Preparation is *essential* and should include education and training, maintenance of emergency equipment and supplies, appropriate use of personnel and formation and implementation of an EAP.
- Ideally, an athletic trainer should be on site during all sporting events. If medical personnel are not present, sports administrators should develop procedures for implementing the EAP and ensuring that all coaches are trained as first responders to ensure appropriate care prior to the arrival of trained medical personnel.

Recommendation 2: It is essential that sports medicine teams conduct a "Time Out" before athletic events to ensure EAPs are reviewed and to plan the options with the personnel and equipment available for that event.

Recommendation 3: Proper assessment and management of the spine injured athlete-patient will result in activation of the EAP in accordance with the level or severity of the injury.

Recommendation 4: Protective athletic equipment should be removed *prior* to transport to an emergency facility for an athlete-patient with suspected cervical spine instability.

Recommendation 5: Equipment removal should be performed by at least three rescuers trained and experienced with equipment removal at the earliest possible time. If fewer than three people are present, the equipment should be removed at the earliest possible time after enough trained individuals arrive on the scene.

Rationale for Equipment Removal

- Recent changes in some emergency medical services (EMS) protocols have impacted management of spine injuries in the field and during preparation for and transportation to hospital emergency departments. In the past, it was recommended that protective equipment (e.g., helmets and shoulder pads in football, hockey and lacrosse) be left in place for transport and removed upon arrival in the hospital Emergency Department.
- It is essential and now recommended that, when appropriate, in an emergency situation with equipment-intensive sports (e.g., helmets and shoulder pads in football, hockey and lacrosse), the protective equipment be removed prior to transport to the hospital. Rescuers should be able to recognize when it is NOT appropriate to remove equipment on field of play and have a plan to best manage the patient. The rationale for consideration of equipment removal on the field is rooted in, but not limited to, the following concepts:
 - ***Advances in equipment technology***
 - ***Equipment removal should be performed by those with the highest level of training.*** In most cases, athletic trainers have been exposed to more equipment removal training than many other members of the medical team. As a result, individuals on the field may have a greater knowledge of equipment removal procedures than the hospital emergency department staff.
 - ***Expedited access to the athlete-patient for enhanced provider care***
 - ***Chest access is prioritized***

Recommendation 6: Athletic protective equipment varies by sport and activity; and styles of equipment differ within a sport or activity. Therefore, it is essential that the sports medical team be familiar with the types of protective equipment specific to the sport and associated techniques for removal of the equipment.

- A wide variety of facemasks, helmets and shoulder pads exist in the various sports. Members of the medical team should be skilled in facemask, helmet and shoulder pad removal. In an emergency situation, it is important to have access to the airway and chest. As the chest is not accessible when wearing shoulder pads, it is recommended that the medical team remove the shoulder pads on the field of play.

Recommendation 7: A rigid cervical stabilization device should be applied to spine injured athlete-patients prior to transport.

- A rigid cervical collar should be applied at the earliest and most appropriate time possible during pre-hospital procedures. With practice, cervical collars can be placed and removed with manual in-line stabilization and potentially minimal risk.
- The medical team needs to continue manual in-line stabilization even after the rigid cervical collar is applied. Several research studies have demonstrated that rigid cervical collars are not effective in controlling cervical spine motion in all planes of movement. Manual in-line stabilization must be maintained until the athlete-patient has been stabilized on a full body immobilization device and a head immobilization device has been applied.

Recommendation 8: Spine injured athlete-patients should be transported using a rigid immobilization device.

- The transport of the spine injured athlete-patient requires special considerations which may include, but are not limited to the mechanism of injury, size of the athlete-patient, equipment worn by the athlete-patient, and the number and skill level of the sports medical team members.

- Throughout the years different terminology has been used by pre-hospital medical care teams to describe procedures used to prevent iatrogenic spinal cord injuries. Initially spinal traction was used and was followed by spinal immobilization. Sports medical care teams must now recognize the concepts of **spinal motion restriction (SMR)** as compared to spinal immobilization. SMR implies that true spinal immobilization cannot be obtained even with the patient securely strapped to a spine board. Like spinal immobilization, the premise of SMR is to prevent further harm to a spinal cord or column injury.
- Criteria for the use of SMR guidelines and immobilization devices should include:
 - Blunt trauma with altered level of consciousness
 - Spinal pain or tenderness
 - Neurologic complaint (e.g., numbness or motor weakness)
 - Anatomic deformity of the spine
 - High-energy mechanism of injury and any of the following:
 - Drug or alcohol intoxication
 - Inability to communicate
 - Distracting injury
- Recent publications have expressed concern related to the use of the long spine board due to potential harmful effects to the patient if the patient remains on the long spine board for an extended period of time. However, in the case of a potentially spine injured athlete it is recommended that a long spine board or other immobilization device be used for transport.
- The ED medical team is encouraged to assess the athlete-patient on arrival to the ED. Following the assessment, the athlete-patient should be transferred off the spine board to the appropriate hospital bed for further care to decrease chances of pressure sore development and other potential detrimental side effects related to a prolonged length of time on the board.

Recommendation 9: Techniques employed to move the spine injured athlete-patient from the field to the transportation vehicle should minimize spinal motion.

- The spine injured athlete-patient should be transferred to the long spine board or vacuum mattress using a technique that limits spinal motion.
 - In the case of a supine positioned athlete, the medical team should use the 8-person lift (previously described as the six-plus lift) to move the athlete-patient to the long spine board.
 - The scoop stretcher may be employed to lift the supine athlete-patient from the field.
 - In the case of a prone positioned athlete, the medical team should position the spine board and use a log roll push technique to place the athlete-patient on to the long spine board.

Recommendation 10: It is essential that a transportation plan be developed prior to the start of any athletic practice or competition.

Recommendation 11: Spine injured athlete-patients should be transported to a hospital that can deliver immediate, definitive care for these types of injuries.

- The choice of the *most appropriate hospital* should be determined and written in the EAP.
- If definitive care is not readily available, spine injured athlete-patients should be transported to the nearest hospital for stabilization and possible air medical evacuation to the nearest trauma center. Attempts should be made to avoid this extra delay in definitive care as the patient in this scenario might have improved outcomes with expeditious definitive management.
- Emergency medical teams should keep in mind that every time the spine injured athlete-patient is moved, the chance for additional neurological compromise increases. For this reason, transfer of the athlete-patient in the pre-hospital setting and within the ED should be kept to a minimum and appropriate transfer devices should be used.
- ED staff must avail themselves of training modules in the event an athlete arrives with equipment in place.

Recommendation 12: It is essential that prevention of spine injuries in athletics be a priority and requires collaboration between the medical team, coaching staff and athletes.

Recommendation 13: The medical team must have a strong working knowledge of current research, as well as national and local regulations to ensure up-to-date care is provided to the spine injured athlete-patient.

Recommendation 14: It is essential that future research continue to investigate the efficacy of devices used to provide spinal motion restriction.

The National Athletic Trainers' Association (NATA) and the Inter-Association Task Force for Appropriate Care of the Spine Injured Athlete advise individuals, schools, athletic training facilities, and institutions to carefully and independently consider each of the recommendations. The information contained in the statement is neither exhaustive nor exclusive to all circumstances or individuals. Variables such as institutional human resource guidelines, state or federal statutes, rules or regulations, as well as regional environmental conditions, may impact the relevance and implementation of these recommendations. The NATA and the Inter-Association Task Force advise their members and others to carefully and independently consider each of the recommendations (including the applicability of same to any particular circumstance or individual). The foregoing statement should not be relied upon as an independent basis for care but rather as a resource available to NATA members or others. Moreover, no opinion is expressed herein regarding the quality of care that adheres to or differs from any of NATA's other statements. The NATA and the Inter-Association Task Force reserve the right to rescind or modify their statements at any time.

Participating Organizations

American Academy of Family Physicians
American Academy of Neurology
American Academy of Orthopaedic Surgeons – Committee on the Spine
American Academy of Pediatrics – Committee on Sports Medicine and Fitness
American College of Emergency Physicians
American College of Sports Medicine
American College of Surgeons – Committee on Trauma
American Medical Society for Sports Medicine
American Orthopaedic Society for Sports Medicine
Canadian Athletic Therapists' Association
College Athletic Trainers' Society
National Association of EMS Physicians
National Association of EMTs
National Association of Intercollegiate Athletics
National Association of State EMS Officials
National Athletic Trainers' Association
National Collegiate Athletic Association
National Federation of State High School Associations
North American Spine Society
Professional Football Athletic Trainers Society
United States Olympic Committee

SUGGESTED GUIDELINES FOR MANAGEMENT OF HEAD TRAUMA IN SPORTS

Head trauma is a common problem in sports that has the potential for serious complications if not managed correctly. Even what appears to be a “minor ding or bell ringer” without loss of consciousness has a real risk of catastrophic results in a youngster who is returned to action too soon. The medical literature and lay press are reporting instances of death from “second impact syndrome” even after mild concussions. This increased vulnerability of the brain to concussions close together and the cumulative effects of multiple concussions are becoming known risks that need to be addressed.

At many athletic contests across the country, there is a lack of trained and knowledgeable individuals making the decision to return concussed athletes to the game. Frequently, there is undo pressure from various sources (parents, player, and coach) to return a valuable athlete to action ASAP. In addition, there is often unwillingness by the athlete who wants to play to report headaches and other findings that she/he knows will prevent his/her return to play. Research is now revealing some fairly objective, easy-to-use tests that can easily be performed on the sidelines which appear to identify subtle residual deficits that may not be obvious from the traditional evaluation. Although having base line data on the athletes at the time of the pre-participation examination enhances the usefulness of these tests, recent studies suggest the ability to differentiate concussed from non-concussed athletes with some of these instruments. These identifiable deficits frequently persist after the obvious signs of concussion are gone and appear to have relevance to whether an athlete can return to the game in relative safety. The significance of these deficits is still under study and the evaluation instruments represent a work in progress. However, even in their present state of evolution, their effectiveness, validity, and ease of utilization make them a much preferable way to assess a youngster after a concussion than the hit-and-miss methods now being utilized across the country. Again, these should not be utilized exclusively without consideration of the severity and nature of the injury, the interval since the last head injury, the level of play and the clinical judgment of the examiner depending on his or her training.

The National Federation of State School Associations recommends that State Associations distribute this information to the athletic directors in all their member schools so that persons making sideline decisions to allow an athlete to return to play can benefit from the latest knowledge on how to assess concussed athletes for warning signals that might suggest they not return to the game. In addition to the usual observations as to whether the athlete “seems OK,” some assessment of orientation, memory, and coordination at rest and after physical exertion is important to have a comprehensive knowledge of the athlete’s mental status.

We have outlined some guidelines below that may be helpful in establishing a protocol at your institutions. Please bear in mind these are general guidelines and must not be used in place of the central role that physicians and certified athletic trainers must play in protecting the health and safety of student athletes.

CONCUSSION EDUCATION AND MANAGEMENT PROTOCOL

Education

Concussions are common in sports. The Missouri State High School Activities Association (MSHSAA) believes that education of coaches, officials, athletes, and their parents or guardians are key to safely returning a student athlete to play. Appropriate immediate care after a suspected concussion, and follow up incorporating a multi-disciplinary team that includes the coach, parent or guardian, athlete’s physician, team physician and athletic trainer (if available), and school representatives, also are important for the proper management of a sport-related concussion.

Each school district will receive educational materials for coaches, athletes, parents, and school officials, required forms for student athlete participation and parent/guardian consent, and recommended medical clearance forms for return to play.

Annually, MSHSAA member school districts will ensure that every coach, student athlete, and parents or guardians of a student athlete completes a concussion and head injury information sheet and returns it to the school district prior to the student athlete’s participation in practice or competition. Officials will receive training from their parent organization. Each official’s organization will require annual concussion training and maintain a signed head injury information sheet for each official.

Recognition and Evaluation of the Athlete with a Concussion

1. Recognition of the signs and symptoms of a concussion is important. Every member of the team-athlete, teammates, coaches, parents or guardians, officials, athletic trainers, and team physicians have a duty to report a suspected concussion. Not all school districts have medical personnel available to cover every practice and competition; therefore, the coach is the person in the best position to protect the player and must be aware that not all student athletes will be forthcoming about their injury.
2. An official shall not be responsible for making the diagnosis of a concussion. The official can assist coaches and medical staff by recognizing signs and symptoms of a concussion and informing the coach and medical staff of their concerns.
3. The coach, ATC, or physician on site should evaluate the athlete in a systemic fashion :
 - a. Assess for airway, breathing, and circulation (basic CPR assessment).
 - b. Assess for concussion.
 - i. Any unconscious athlete should be assumed to have a severe head and/or neck injury and should have their cervical spine immobilized until a determination can be made that the cervical spine has not been injured. If no medical professional can make the assessment, the athlete should be transported to an appropriate emergency care facility.
 - ii. A conscious athlete with no neck pain can be further evaluated on the sideline.
4. An athlete experiencing ANY of the signs/symptoms of a concussion should be immediately removed from play. Signs/Symptoms of a concussion include:

<u>PHYSICAL</u>	<u>COGNITIVE</u>	<u>EMOTIONAL</u>
Headache	Feeling mentally "foggy"	Irritability
Nausea/Vomiting	Feeling slowed down	Sadness
Dazed/Stunned	Difficulty concentrating	More emotional
Balance problems	Difficulty remembering	Nervousness
Visual problems	Forgetful of recent information	
Fatigue	Confused about recent events	
Sensitivity to light	Answers questions slowly	
Sensitivity to noise	Repeats questions	

5. Evaluation

- a. Following any first aid management, the medical team, or coach in the absence of medical personnel, should assess the athlete to determine the presence or absence of a concussion. The SCAT (Sideline Concussion Assessment Tool) and SCAT2 are effective assessment tools that are readily available and can assist with the assessment.
- b. The athlete should be monitored for worsening or change in signs and symptoms over the next 24 hours. Instructions should be given to the parent or guardian as to signs and symptoms that may require further or more emergent evaluation.

6. Management of a Concussion and Return to Play

- a. An athlete determined to have a concussion or have concussion-like symptoms will be removed from practice or competition and is not allowed to return to practice or competition that same day.
- b. If an athlete displays concussion-like signs or symptoms, the athlete should be assumed to have a concussion until further medical evaluation can occur. "WHEN IN DOUBT, SIT THEM OUT!"
- c. Written clearance from a physician (MD or DO), Advanced Nurse Practitioner in written collaborative practice with a physician, Certified Physician Assistant in written collaborative practice with a physician, or Certified Athletic Trainer in written supervision of a physician, must be provided prior to return to play.
- d. Following a concussion, the athlete should have both physical and cognitive rest until symptoms have resolved.
- e. An athlete must be asymptomatic at rest and with exertion prior to return to play
- f. A graduated return to play protocol has been outlined by the Third International Concussion in Sport Group Statement (2008, Zurich), is recommended by the NFHS (nfhs.org), and may be used to guide return to play following medical clearance.

