

# SCAT 2

## Sport Concussion Assessment Tool

NAME: \_\_\_\_\_

SPORT: \_\_\_\_\_

DATE/TIME OF INJURY: \_\_\_\_\_

DATE/TIME OF ASSESSMENT: \_\_\_\_\_

AGE: \_\_\_\_\_ GENDER: M F

GRADE \_\_\_\_\_ SCHOOL \_\_\_\_\_

EXAMINER: \_\_\_\_\_

### The SCAT 2 Symptom Evaluation

**How do you feel?** You should score yourself on the following symptoms, based on how you feel now.

	None		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
Trouble falling asleep	0	1	2	3	4	5 6
More emotional than usual	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

Total number of symptoms (Maximum possible 22) \_\_\_\_\_

### Symptom SCORE

22 minus positive symptoms: \_\_\_\_\_ of 22

### Symptom Severity Score

(Sum of all scores. Max possible 22x6=132) \_\_\_\_\_

Do the symptoms get worse with physical activity ☐ y ☐ n

Do the symptoms get worse with mental activity ☐ y ☐ n

### Overall rating

If you know the athlete well prior to injury, how different is the athlete acting compared to his/her usual self? Please check one response

☐ No different ☐ very different ☐ unsure

### PHYSICAL SIGNS SCORE

Was there loss of consciousness/unresponsiveness? Y N  
If yes, how many minutes: \_\_\_\_\_

Was there a balance problem/unsteadiness? Y N

Physical signs score (1 pt. for each negative) \_\_\_\_\_ of 2

### GLASGOW COMA SCALE (GCS)

#### Best eye response (E)

No eye opening \_\_\_\_\_ 1  
Eyes opening in response to pain \_\_\_\_\_ 2  
Eyes opening to speech \_\_\_\_\_ 3  
Eyes opening spontaneously \_\_\_\_\_ 4

#### Best verbal response (V)

No verbal response \_\_\_\_\_ 1  
Incomprehensible sounds \_\_\_\_\_ 2  
Inappropriate words \_\_\_\_\_ 3  
Confused \_\_\_\_\_ 4  
Oriented \_\_\_\_\_ 5

#### Best motor response (M)

No motor response \_\_\_\_\_ 1  
Extension to pain \_\_\_\_\_ 2  
Abnormal flexion to pain \_\_\_\_\_ 3  
Flexion/withdrawal to pain \_\_\_\_\_ 4  
Localizes to pain \_\_\_\_\_ 5  
Obeys commands \_\_\_\_\_ 6

Glasgow Coma score (E + V + M) \_\_\_\_\_ of 15  
GCS should be recorded for all athletes in case of subsequent deterioration.

### Sideline Assessment – Maddocks Score

#### Modified Maddocks questions (1 pt. for each correct)

At what venue are we at today? 0 1  
Which half is it now? 0 1  
Who scored last? 0 1  
What team did you play last? 0 1  
Did you win your last game? 0 1

Maddocks score: \_\_\_\_\_ of 5

Maddocks score is validated for sideline diagnosis of concussion only and is not included in the summary score for serial testing.

### Coordination Exam

#### Upper Limb Coordination – Finger-to-nose task:

Which arm was tested: right left

Scoring: 5 correct repetitions in &lt; 4 sec. = 1

Coordination score: \_\_\_\_\_ of 1

**Must fully touch nose and fully extend elbow after touching nose.**

# SCAT 2

## Sport Concussion Assessment Tool

### Cognitive Assessment

#### Standardized Assessment of Concussion (SAC)

##### Orientation (1 pt. for each correct)

What month is it?	0	1
What is today's date?	0	1
What day of the week is it?	0	1
What year is it?	0	1
What time is it right now? (within 1 hr.)	0	1

Orientation score \_\_\_\_\_ of 5

##### Immediate Memory (1 pt. for each correct)

List	Trial 1	Trial 2	Trial 3	Alternative Words
Elbow	Y N	Y N	Y N	candle baby finger
Apple	Y N	Y N	Y N	paper monkey penny
Carpet	Y N	Y N	Y N	sugar perfume blanket
Saddle	Y N	Y N	Y N	table sunset lemon
Bubble	Y N	Y N	Y N	wagon iron insect

(Circle all words used. The athlete should repeat words in order. Complete all 3 trials regardless of score on trail 1 & 2. Do not inform the athlete that delayed recall will be tested. Total score equals sum across all 3 trials).

Immediate memory score \_\_\_\_\_ of 15

##### Concentration

*Digits Backwards (1 pt. possible for each string length)*

			Alternative digit list
4-9-3	Y	N	6-2-9 5-2-6 4-1-5
3-8-1-4	Y	N	3-2-7-9 1-7-9-5 4-9-6-8
6-2-9-7-1	Y	N	1-5-2-8-6 3-8-5-2-7 6-1-8-4-3
7-1-8-4-6-2	Y	N	5-3-9-1-4-8 8-3-1-9-6-4 7-2-4-8-5-6

*Months in Reverse Order (1 pt. for entire sequence correct)*

Dec-Nov-Oct-Sept-Aug-Jul-Jun-May-Apr-Mar-Feb-Jan Y N

Concentration score \_\_\_\_\_ of 5

### Balance Examination

#### Modified BESS Test

Non-dominant foot: Right Left

Double-leg Stance (20 seconds) \_\_\_\_\_ of 10

Single-leg Stance (20 seconds) \_\_\_\_\_ of 10

Tandem Stance (20 seconds) \_\_\_\_\_ of 10

(Non-dominant foot in back)

Trials are scored by counting all errors or deviations from the proper stance during the three 20 second intervals.

##### Types of errors include:

Hands off iliac crest  
Opening eyes  
Step, stumble or fall  
Moving hip into >30 degrees abduction  
Remaining out of testing position >5 seconds

Balance exam score (30-total errors) \_\_\_\_\_ of 30

### Cognitive Assessment

#### Standardized Assessment of Concussion (SAC)

##### Delayed Recall

*Ask athlete to recall the list of words read earlier in any order.*

Elbow	candle	baby	finger
Apple	paper	monkey	penny
Carpet	sugar	perfume	blanket
Saddle	table	sunset	lemon
Bubble	wagon	iron	insect

Delayed recall score \_\_\_\_\_ of 5

### Overall Score

Test Domain	Score
Symptom score	_____ of 22
Physical signs score	_____ of 2
Glasgow coma score (E + V + M)	_____ of 15
Coordination score	_____ of 1
Balance score	_____ of 30
<b>Subtotal</b>	<b>_____ of 70</b>
Orientation score (SAC)	_____ of 5
Immediate memory score (SAC)	_____ of 15
Concentration score (SAC)	_____ of 5
Delayed recall score (SAC)	_____ of 5
<b>SAC subtotal</b>	<b>_____ of 30</b>
<b>SCAT 2 total</b>	<b>_____ of 100</b>
<b>Maddocks total</b>	<b>_____ of 5</b>

*Scoring data from the SCAT2 or SAC should not be used as a stand alone method to diagnose concussion, measure recovery, or make return to play*



# CONCUSSION ACKNOWLEDGEMENT FORM

Name of Student \_\_\_\_\_

**Definition of Concussion** - means a complex pathophysiological process affecting the brain caused by a traumatic physical force or impact to the head or body, which may: (A) include temporary or prolonged altered brain function resulting in physical, cognitive, or emotional symptoms or altered sleep patterns; and (B) involve loss of consciousness.

**Prevention** - Teach and practice safe play & proper technique.

- Follow the rules of play.
- Make sure the required protective equipment is worn for all practices and games.
- Protective equipment must fit properly and be inspected on a regular basis.

**Signs and Symptoms of Concussion** - The signs and symptoms of concussion may include but are not limited to: Head ache, appears to be dazed or stunned, tinnitus (ringing in the ears), fatigue, slurred speech, nausea or vomiting, dizziness, loss of balance, blurry vision, sensitive to light or noise, feel foggy or groggy, memory loss, or confusion.

**Oversight** - Each district shall appoint and approve a Concussion Oversight Team (COT). The COT shall include at least one physician and an athletic trainer if one is employed by the school district. Other members may include: Advanced Practice Nurse, neuropsychologist or a physician's assistant. The COT is charged with developing the Return to Play protocol based on peer reviewed scientific evidence.

**Treatment of Concussion** - The student-athlete shall be removed from practice or competition immediately if suspected to have sustained a concussion. Every student-athlete suspected of sustaining a concussion shall be seen by a physician before they may return to athletic participation. The treatment for concussion is cognitive rest. Students should limit external stimulation such as watching television, playing video games, sending text messages, use of computer, and bright lights. When all signs and symptoms of concussion have cleared and the student has received written clearance from a physician, the student-athlete may begin their district's Return to Play protocol as determined by the Concussion Oversight Team.

**Return to Play** - According to the Texas Education Code, Section 38.157:

A student removed from an interscholastic athletics practice or competition under Section 38.156 may not be permitted to practice or compete again following the force or impact believed to have caused the concussion until:

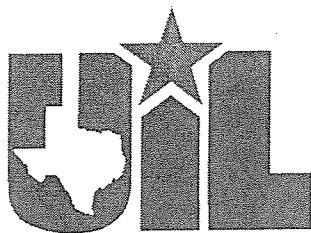
- (1) the student has been evaluated, using established medical protocols based on peer-reviewed scientific evidence, by a treating physician chosen by the student or the student's parent or guardian or another person with legal authority to make medical decisions for the student;
- (2) the student has successfully completed each requirement of the return-to-play protocol established under Section 38.153 necessary for the student to return to play;
- (3) the treating physician has provided a written statement indicating that, in the physician's professional judgment, it is safe for the student to return to play; and
- (4) the student and the student's parent or guardian or another person with legal authority to make medical decisions for the student:
  - (A) have acknowledged that the student has completed the requirements of the return-to-play protocol necessary for the student to return to play;
  - (B) have provided the treating physician's written statement under Subdivision (3) to the person responsible for compliance with the return-to-play protocol under Subsection (c) and the person who has supervisory responsibilities under Subsection (c); and
  - (C) have signed a consent form indicating that the person signing:
    - (i) has been informed concerning and consents to the student participating in returning to play in accordance with the return-to-play protocol;
    - (ii) understands the risks associated with the student returning to play and will comply with any ongoing requirements in the return-to-play protocol;
    - (iii) consents to the disclosure to appropriate persons, consistent with the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191), of the treating physician's written statement under Subdivision (3) and, if any, the return-to-play recommendations of the treating physician; and
    - (iv) understands the immunity provisions under Section 38.159.

\_\_\_\_\_  
Parent or Guardian Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Student Signature

\_\_\_\_\_  
Date



# Concussion Management Protocol Return to Play Form

*This form must be completed and submitted to the athletic trainer or other person (who is not a coach) responsible for compliance with the Return to Play protocol established by the school district Concussion Oversight Team, as determined by the superintendent or their designee (see Section 38.157 (c) of the Texas Education Code).*

\_\_\_\_\_  
*Student Name (Please Print)*

\_\_\_\_\_  
*School Name (Please Print)*

## Designated school district official verifies:

*Please Check*

- ☐ The student has been evaluated by a treating physician selected by the student, their parent or other person with legal authority to make medical decisions for the student.
- ☐ The student has completed the Return to Play protocol established by the school district Concussion Oversight Team.
- ☐ The school has received a written statement from the treating physician indicating, that in the physician's professional judgment, it is safe for the student to return to play.

\_\_\_\_\_  
*School Individual Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*School Individual Name (Please Print)*

## Parent, or other person with legal authority to make medical decisions for the student signs and certifies that he/she:

*Please Check*

- ☐ Has been informed concerning and consents to the student participating in returning to play in accordance with the return to play protocol established by the Concussion Oversight Team.
- ☐ Understands the risks associated with the student returning to play and will comply with any ongoing requirements in the return to play protocol.
- ☐ Consents to the disclosure to appropriate persons, consistent with the Health Insurance Portability and Accountability Act of 1996 (Pub. L. No. 104-191), of the treating physician's written statement under Subdivision (3) and, if any, the return to play recommendations of the treating physician.
- ☐ Understands the immunity provisions under Section 38.159 of the Texas Education Code.

\_\_\_\_\_  
*Parent/Responsible Decision-Maker Signature*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Parent/Responsible Decision-Maker Name (Please Print)*