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# PROTECTING PLAYERS

NFL Head, Neck and Spine Committee's Concussion Diagnosis and Management Protocol

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## SUMMARY

The **NFL Head, Neck and Spine Committee**—a board of independent and NFL-affiliated physicians and scientists, including advisors for the NFL Players Association—developed the NFL Game Day Concussion Diagnosis and Management Protocol in 2011. The Concussion Protocol is reviewed each year to ensure players are receiving care that reflects the most up-to-date medical consensus on the identification, diagnosis, and treatment of concussions.

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*Amended June 2017*

## I. Overview of Injury

### Introduction

Concussion is an important injury for the professional football player, and the diagnosis, prevention, and management of concussion is important to the National Football League, its players and member Clubs, and the National Football League Players Association. The NFL's Head, Neck and Spine Committee has developed a comprehensive set of protocols regarding

the diagnosis and management of concussions in NFL players.

The diagnosis and management of concussion is complicated by the difficulty in identifying the injury as well as the complex and individual nature of managing this injury. Ongoing education of players, NFL team physicians and certified athletic trainers (ATCs) regarding concussion is important, recognizing the evolving advances in concussion assessment and management. The objective of these protocols is to provide medical staffs responsible for the health care of NFL players with a guide for diagnosing and managing concussion.

This document updates and supersedes the initial “NFL Head, Neck and Spine Committee’s Protocols Regarding Diagnosis and Management of Concussion”, issued in July, 2013, and all subsequent amendments thereto.

### Concussion Defined

For purposes of these protocols, the term *concussion* is defined as (*adapted from McCrory et al. BJSM ‘17*):

Sports related concussion (“SRC”) is a traumatic brain injury induced by biomechanical forces. Several common features that may be utilized in clinically defining the nature of a concussive head injury include the following:

1. SRC may be caused either by a direct blow to the head, face, neck or elsewhere on the body with an impulsive force transmitted to the head.
2. SRC typically results in the rapid onset of short-lived impairment of neurological function that resolves spontaneously. However, in some cases, signs and symptoms evolve over a number of minutes to hours.
3. SRC may result in neuropathological changes, but the acute clinical signs and symptoms largely reflect a functional disturbance rather than a structural injury and, as such, no abnormality is seen on standard structural neuroimaging studies.
4. SRC results in a range of clinical signs and symptoms that may or may not involve loss of consciousness. Resolution of the clinical and cognitive features typically follows a sequential course. However, in some cases symptoms may be prolonged.

### Potential Concussion Signs (Observable)

- Any loss of consciousness;
- Slow to get up following a hit to the head (“hit to the head” may include secondary contact

with the playing surface);

- Motor coordination/balance problems (stumbles, trips/falls, slow/labored movement);
- Blank or vacant look;
- Disorientation (e.g., unsure of where he is on the field or location of bench);
- Amnesia, both anterograde and retrograde;
- Clutching of head after contact; or
- Visible facial injury in combination with any of the above.

### Potential Concussion Symptoms

- Headache;
- Dizziness;
- Balance or coordination difficulties;
- Nausea;
- Amnesia, both anterograde and retrograde;
- Cognitive slowness;
- Light/sound sensitivity;
- Disorientation;
- Visual disturbance; or
- Tinnitus.

## **II. NFL Head, Neck and Spine Committee's Concussion Protocol**

### **Emergency Action Plan**

An Emergency Medical Action Plan (EAP) must be developed, written, discussed, practiced and reviewed by every club's medical staff for all practice and game venues, as well as conditioning and training sites. Each EAP must establish the protocols that the medical staff must follow in the event of significant injury, including head trauma. The EAP must include a list of approved, certified Booth ATC Spotters for the stadium and a list of certified and approved emergency room physicians to serve as medical liaisons for the visiting team (VTMLs). The EAP must be

submitted and approved by an expert designated by the parties and confirmed by the NFL Chief Medical Officer and the NFLPA Medical Director. The EAP must be sent to the visiting club's medical team in advance of all games.

## **Preseason**

Education: Players and club personnel must be provided with, and must review, educational materials regarding concussion, including the importance of identifying and reporting signs and symptoms to the medical staff. These educational materials shall provide basic facts about concussion, including signs and symptoms, as well as why it is important to report symptoms promptly. Additionally, players must be educated and encouraged to report to the medical staff concussion signs and symptoms that their teammates may experience.

### Preseason Assessment:

- Physical Examination: The team physician should use the preseason physical examination to review and answer questions about a player's previous concussions, discuss the importance of reporting any concussive signs or symptoms, and explain the specifics regarding the concussion diagnosis and management protocol. Team doctors should also explain the various roles of the participants in the concussion protocol (e.g., UNC's and INC's).
- Neuropsychological testing: Every player must be given a baseline physical examination as part of his preseason physical examination which shall include a traditional neurological examination and Baseline NFL Locker Room Comprehensive Concussion Assessment (Attachment B). This information shall be used in evaluating the player if he subsequently sustains a concussion during the season. Each player is required to have a baseline neuropsychological test. Computerized forms of neuropsychological testing are used, but it is also acceptable to perform standard paper and pencil testing or to utilize a combination of the two.

## **Game Day Concussion Diagnosis and Management**

### Definitions/Responsible Parties

- **Unaffiliated Neurotrauma Consultant ("UNC")**

During games, each team will be assigned an Unaffiliated Neurotrauma Consultant ("UNC") by the NFL Head, Neck and Spine Committee and approved by the NFL Chief Medical Officer and the NFLPA Medical Director. Each UNC shall be a physician who is impartial and independent from any Club, is board certified or board eligible in neurology, neurological

surgery, emergency medicine, physical medicine and rehabilitation, or any primary care CAQ sports medicine certified physician and has documented competence and experience in the treatment of acute head injuries (as evidenced by no less than monthly treatment of such patients). A UNC shall be present on each sideline during every game and shall be (i) focused on identifying symptoms of concussion and mechanisms of injury that warrant concussion evaluation, (ii) working in consultation with the Head Team Physician or designated TBI team physicians to implement the concussion evaluation and management protocol (including the Locker Room Comprehensive Concussion Assessment Exam) during the games, and (iii) present to observe (and collaborate when appropriate with the team physician) the Sideline Concussion Assessment Exams performed by club medical staff. These unaffiliated consultants also will be available to assist in transportation to an appropriate facility for more advanced evaluation and/or treatment as needed based on the EAP. These consulting physicians will work with the team's medical staff and will assist in the diagnosis and care of the concussed player. The team physician/UNC unit will be co-located for all concussion evaluations and management both on and off the field. [1] The UNC may present his/her own questions or conduct additional testing and shall assist in the diagnosis and treatment of concussions. Regardless, the responsibility for the diagnosis of concussion and the decision to return a player to a game remains exclusively within the professional judgment of the Head Team Physician or the team physician assigned to managing TBI. The UNC will also be present for sideline evaluations for neuropraxia ("stingers" or "burners") and other potential neck injuries.

- **Booth Certified Athletic Trainer Spotter ("Booth ATC Spotters")**

Two certified athletic trainers will be assigned to a stadium booth with access to multiple views of video and replay to aid in the recognition of injury ("Booth ATC Spotters"). Booth ATC Spotters will follow the NFL Concussion Protocol and are charged with monitoring the game, both live and via video feed, to identify players that may require additional medical evaluation. Prior to the start of the game, Booth ATC Spotters will introduce themselves to the medical staff for both teams to discuss protocol and confirm that all communication devices are operational. The Booth ATC Spotters, UNC and the team physician shall be connected by radio communication. The Booth ATC Spotters shall also be connected to the on-field game officials by radio communication. The teams' medical personnel may initiate communication with the spotter to clarify the manner of injury. The sideline medical staff will be able to review the game film on the sidelines to obtain information on particular plays involving possible injury. When the Booth ATC Spotter observes a player who is clearly unstable, or displays any other Potential Concussion Signs (defined in Section I.C. above) following a mechanism of injury (e.g., a hit to the head or neck), he/she will contact the team

physician and UNC by radio to ensure that a concussion evaluation is undertaken on the sideline. The club medical staff will then verify to the Booth ATC Spotter that the evaluation has been performed. The Booth ATC Spotter shall note the time of his initial contact with the club medical staff and UNC alerting them of the need for further evaluation and also the time of the communication from the club medical staff and UNC confirming that an evaluation has been performed. This information is to be conveyed in the Booth ATC Spotter's report following the game. If the Booth ATC Spotter observes a player who he has flagged for medical evaluation return to the game prior to receiving the confirmation from the team's medical staff that an evaluation was conducted, the Booth ATC Spotter shall call a medical time out (see below). For purposes of clarity, this is intended to serve as a redundant communication from the Booth ATC Spotter with the team physician or UNC to confirm that a concussion evaluation has been performed. If no such confirmation is provided, the Booth ATC Spotter is required to call a medical timeout to assure the concussion evaluation occurs. Booth ATC Spotters shall file a report of their activity following each game for review by the NFL Chief Medical Officer and NFLPA Medical Director.

### Game Day Symptoms/Return to Play

- **“No-Go” Signs and Symptoms.** If a player exhibits or reports any of the following signs or symptoms of concussion, he must be removed immediately from the field of play and transported to the locker room. A player who exhibits or reports any of the following signs or symptoms shall be considered to have suffered a concussion and may not return to participation (practice or play) on the same day under any circumstances:

- Loss of Consciousness
- Confusion
- Amnesia

- **NFL Sideline Concussion Assessment (Sideline Survey)**

If a player exhibits or reports a sign or symptom of concussion (defined above) or a concern is raised by the club's athletic trainer, team physicians, Booth ATC Spotter, coach, teammate, game official or Unaffiliated Neurotrauma Consultant (collectively referred to as “gameday medical personnel”) the player must be immediately removed to the sideline or stabilized on the field, as needed, and must undergo the entire NFL Sideline Concussion Assessment <sup>[2]</sup> which, at a minimum, must consist of the following:

- A review of the “No-Go” criteria reviewed above (Loss of Consciousness, Confusion, and Amnesia), which, if present, requires the player to be brought to the locker room immediately and he shall not return to play;
- Inquiry regarding the history of the event;
- Review of concussion signs and symptoms (See, Section I (C and D));
- Maddock’s questions;
- Video Review of the injury (detailed below); and
- Focused Neurological Exam, inclusive of the following:
  - Cervical Spine Examination (including range of motion and pain);
  - Evaluation of speech;
  - Observations of gait; and
  - Eye Movements and Pupillary Exam.

The foregoing shall be (i) conducted inside the medical evaluation tent on the sideline and (ii) performed using the tablet or other technology assigned by the NFL, and completion of each component of the Sideline Survey shall be confirmed using the same. If *any* elements of the sideline assessment are positive, inconclusive, or suspicious for the presence of a concussion, the player must be escorted to the locker room immediately for the complete NFL Locker Room Comprehensive Concussion Assessment. Also, if the player demonstrates worsening or progressing symptoms at any point, he is to be brought to the locker room for the complete NFL Locker Room Comprehensive Concussion Assessment. The player will be accompanied by, at least, the team physician best qualified to evaluate concussion and the UNC. The UNC may present his/her own questions or conduct additional testing.

If, upon completing the Sideline Survey, the medical staff concludes that the player *did not* sustain a concussion, then the player may return to play.

Suggested best practices for concussion assessment include periodic checks by the team physician, UNC or others with the player to determine whether he has developed any of the signs or symptoms of concussion that would necessitate a locker room evaluation.

## UNC Involvement in Sideline Concussion Assessment:

1. The team physician will consult in private with the members of his/her team's medical staff designated to identify, diagnose and treat concussions, the UNC and, as necessary, the club's ATC, prior to making his/her decision regarding whether the player will return to the game.
2. If the team physician determines that the player shall not return to play (based on the criteria listed in Section 2.a. above) and therefore there is no need to complete the Sideline Concussion Assessment, the team physician and the UNC shall accompany the player to the locker room to evaluate the player using the Locker Room Comprehensive Concussion Evaluation (see below) for serious injury, treat the player, or activate the EAP if indicated.
3. The team physician remains responsible for all final decisions regarding Return-to-Play. However, the team physician will consult with his/her UNC team member prior to reaching his/her decision. If the UNC disagrees with the team physician's decision to return the player to play or remove the athlete, the UNC will be given an opportunity to explain the basis of his/her opinion. This will be discussed in a collegial fashion in private as to why that the player should or should not be returned to the game. The team physician will communicate his final decision to the player.

### ● **NFL Locker Room Comprehensive Concussion Assessment (Locker Room Exam)**

The NFL Locker Room Comprehensive Concussion Assessment is the standardized acute evaluation that has been developed by the NFL's Head Neck and Spine Committee to be used by teams' medical staffs and designated Unaffiliated Neurotrauma Consultant to evaluate potential concussions during practices and on game day. This evaluation is based on the Standardized Concussion Assessment Tool (SCAT 5) published by the International Concussion in Sport Group (McCroory '17), modified for use in the NFL and consistent with the SCAT5 published in 2017 (Attachment A). The NFL Locker Room Comprehensive Concussion Assessment can be used to aid in the diagnosis of concussion even if there is a delayed onset of symptoms. The ongoing use of the Locker Room Comprehensive Concussion Assessment in conjunction with the preseason baseline testing provides a comprehensive and detailed picture of each athlete's injury and recovery course. Being able to compare the results from the NFL Locker Room Comprehensive Concussion Assessment to the baseline information obtained in the preseason improves the value of this instrument. Clubs shall maintain all NFL Locker Room Comprehensive Concussion Assessment exams and a copy of



the same shall be given to both the player and the team medical staff. In all circumstances, the team physician responsible for concussion evaluation or other physician designated by the team physician (e.g., neurosurgeon or Neurotrauma Consultant) shall assess the player in person in conjunction with the Unaffiliated Neurotrauma Consultant (UNC). The team physician shall be responsible for determining whether the player is diagnosed as having a concussion. The athlete may have a concussion despite being able to complete the NFL Locker Room Comprehensive Concussion Assessment “within normal limits” compared to their baseline, due to the limitations of the Assessment. Such limitations underscore the importance of knowing the athlete and the subtle deficits in their personality and behaviors that can occur with concussive injury. The signs and symptoms of concussion listed above (Section I, C and D), although frequently observed or reported, are not an exhaustive list. The NFL Locker Room Comprehensive Concussion Assessment is intended to capture these elements in a standardized format. The neurocognitive assessment in the NFL Locker Room Comprehensive Concussion Assessment is brief and does not replace more formal neuropsychological test data. A balance assessment is an important component of the NFL Locker Room Comprehensive Concussion Assessment, and has been validated as a useful adjunct in assessing concussive injury.

### Medical Time-Out

In the event the Booth ATC Spotter: (i) has clear visual evidence that a player displays obvious signs of disorientation, is clearly unstable, or displays other obvious sign of concussion; and (ii) it becomes apparent that the player will remain in the game and not be attended to by the club’s medical or athletic training staff, then the Booth ATC Spotter will take the following steps:

1. If the player does not receive immediate medical attention, contact the Side Judge over the Official-to-Official communication system to identify the player by his team and jersey number.
2. Contact the medical staff of the player involved and advise that the player appears to need medical attention.
3. The Booth ATC Spotter shall remain in contact with the medical staff until the medical staff confirms that a concussion evaluation has occurred or is underway. It is the Booth ATC Spotter’s responsibility to confirm that a concussion evaluation has occurred prior to the player returning to play. As detailed above, if a Booth ATC Spotter observes a player returning to the game without receiving express confirmation that an evaluation has occurred, the Booth ATC Spotter shall signal to the official for a medical timeout.

Upon being called by the Booth ATC Spotter, the Side Judge will immediately stop the game, go to the player in question, and await the arrival of the club's medical personnel to ensure that the player is attended to and escorted off the field. The game and play clock will stop (if running), and remain frozen until the player is removed from the game. Both clocks will start again from the same point unless the play clock was inside 10 seconds, in which case it will be reset to 10. The team of the player being removed will have an opportunity to replace him with a substitute, and the opponent will have an opportunity to match up as necessary. No communication via coach-to-player headsets will be permitted during the stoppage; no member of the coaching staff may enter the playing field; and no player other than the player receiving medical attention may go to the sideline unless a substitute player has replaced him.

Once removed from the field, the team medical staff will conduct an evaluation of the player as required by the governing Protocols before making any decision regarding the player's eligibility to return to play. The medical staff will make the return-to-play decision consistent with the NFL Protocols. In no instance will this evaluation period last less than one play, unless there is an extended delay unrelated to the player's removal from the game (i.e., timeout, two-minute warning, penalty, etc.). An injury timeout will not be charged to a team who has a player removed during this process.

Following the game, both the UNC and team physician are required to document each step outlined above and their conclusions regarding the player's status. The UNC report shall detail each evaluation, including interactions with players and members of the club medical staff, and will be sent to the NFL Chief Medical Officer and NFLPA Medical Director following the game.

### Madden Rule

On game day, per the Madden Rule, a player diagnosed with a concussion must be removed from the field of play and observed in the locker room by qualified medical personnel. The Madden Rule is intended to protect the players by providing a quiet environment, with appropriate medical supervision, to permit the player time to recover without distraction. Once a player is diagnosed with a suspected concussion, he is not permitted to meet or talk to the press until he is medically cleared.

### Additional Evaluations and Follow Up

- A player diagnosed with concussion should have the entire sideline exam performed on the day of injury. The components of the NFL Locker Room Comprehensive Concussion Assessment may be performed at different times on the day of the injury depending on the

individual situation (e.g., exceptions for a player who is transported to the emergency department), and an assessment should be repeated prior to discharge home or prior to transportation home following an away game.

- Performing serial concussion evaluations may be useful because concussive injury can evolve and may not be apparent for several minutes or hours. Even if a player passes an initial concussion assessment and is returned to practice or play, he must be checked periodically during practice or play and again before leaving the venue. Components of the NFL Locker Room Comprehensive Concussion Assessment may be utilized in the performance of such evaluations:
  - The results of subsequent exams by the team physician should be communicated to the UNC in the spirit of “concussion team” cooperation and patient safety, especially if the UNC is not immediately present.
  - Should the sideline examination reveal a change in the player’s condition, the team physician/UNC team will be re-assembled and perform subsequent locker room evaluation.
  - It is important to recognize that players may be able to equal or exceed their performance under the Locker Room Comprehensive Concussion Assessment compared to their baseline level yet still have a concussion, underscoring the importance of the physicians’ knowledge of the player. If there is any doubt about the presence of a concussion, regardless of the Locker Room Comprehensive Concussion Assessment results, the player is to be removed from practice or play. A player diagnosed with concussion will be given “take home” information (e.g. signs and symptoms to watch for, emergency phone numbers) as well as follow up instructions.

### **III. NFL Concussion Game Day Checklist**

The NFL Concussion Game Day Checklist is intended to provide a clear summary of the steps required by NFL Head, Neck and Spine Committee’s Concussion Diagnosis and Management Protocol, with regard both to Sideline Survey and the Locker Room Exam. The NFL Concussion Game Day Checklist (Attachment C) is incorporated herein by reference. The application of the NFL Concussion Game Day Checklist to evaluate potential concussions during NFL preseason and regular season games is *mandatory*. Designated medical personnel (team physicians and athletic trainers, Unaffiliated Neurotrauma Consultants, and Booth ATC Spotters must complete their designated steps in the NFL Concussion Game Day Checklist and record the same using

the designated technology (i.e., X2 system on tablet or other technologies which may be developed). A club medical team's failure to properly apply the NFL Concussion Checklist may subject their club to discipline.

## **IV. Return to Participation Protocol**

### Introduction

Each player and each concussion is unique. Therefore, there is no set time-frame for return to participation or for the progression through the steps of the graduated exercise program set forth below. Recovery time will vary from player to player. The decision to return a player (hereinafter referred to as the "player-patient"), to participation remains within the professional judgment of the Head Team Physician or team physician designated for concussion evaluation and treatment, performed in accordance with these Protocols. All return to full participation decisions are to be confirmed by the Independent Neurological Consultant (INC).<sup>[3]</sup> The INC should be informed when a concussion occurs so that consultation at a medically appropriate time can be arranged. The team physician may consult with the INC as often as desired during the concussion recovery period. The INC will be consulted specifically to answer the question of the player-patient's neurological health and his full return to competitive participation (see Step 5 below). The final clearance for return to play is a decision made by the team's medical staff and must be confirmed by the INC.

After a player-patient has been diagnosed with a concussion, he must be monitored daily, or more frequently if clinically indicated in the opinion of the team physician, through the Return-to-Participation Protocol (described below). Team medical staff should consider the player-patient's current concussive injury, including an in-depth consideration of past exposures, medical history, family history, and future risk in managing the player-patient's care.

After having been diagnosed with a concussion, the player-patient must progress through the following protocol to return to participation. A player-patient may proceed to the next step in the protocol only after he has demonstrated tolerance of all activities in his current step without recurrence of signs or symptoms of concussion being observed or reported. Should the activities of a step trigger recurrence of signs or symptoms of concussion, those activities should be discontinued and the player-patient returned to the prior step in the protocol. The player-patient must remain at his pre-concussion baseline level of signs and symptoms during the exertion itself, as well as for a reasonable period of time afterward. What constitutes a

reasonable amount of time shall be determined on a case-by-case basis by the team physician. Depending on the severity of the concussion and the time required for return to baseline, the progression through the steps may be accelerated. Communication between the medical staff and the player-patient is essential to determining the progression through the steps of the protocol.

The Return-To-Participation Protocol:

### **Step One: Rest and Recovery**

This is the physical and relative cognitive rest step. The player-patient is prescribed rest, limiting or, if necessary, avoiding activities (both physical and cognitive) which increase or aggravate symptoms until his signs and symptoms and neurologic examination, including cognitive and balance tests, return to baseline status. During this step, the player-patient may engage in limited stretching and balance activity as tolerated at the discretion of the medical staff. Should additional issues present, the team physician should consider external consultation or additional diagnostic examinations.

Once the player-patient is at his baseline level of signs and symptoms and neurological examination, he may be cleared to proceed to the next step.

Neurocognitive testing is administered to assess the player-patient's level of cognitive function and identify any acute / subacute deficits that would affect his ability to resume normal activities. Neurocognitive testing can be introduced any time after completing Step One, or during Steps Two or Three, as long as it is completed prior to the initiation of contact activities. The timing of neurocognitive testing is up to the team physician with consultation from the team's neuropsychology consultant. All neurocognitive tests are to be interpreted by the team's neuropsychology consultant, with the results communicated to the team physician.

### **Step Two: Light Aerobic Exercise**

Step Two involves the initiation of a graduated exercise program. Under the direct oversight of the team's medical staff, the player-patient should begin graduated cardiovascular exercise (e.g., stationary bicycle, treadmill) and may also engage in dynamic stretching and balance training. The duration and intensity of all activity may be gradually increased so long as the player-patient remains at baseline while performing the activity and for a reasonable period thereafter. If there is recurrence of signs or symptoms the activity should be discontinued. He may attend regular team meetings and engage in film study.

If neurocognitive testing was not administered during Step One, it should be administered during Step Two or Three. If a player-patient's initial neurocognitive testing is not interpreted as back to baseline by the consulting team neuropsychologist, the tests will be repeated at a time interval agreed upon by the team physician and consulting team neuropsychologist (typically 48 hours). Additionally, a comprehensive evaluation of potential non-injury related causes of a noted neuropsychological decrement should be performed by the team physician. An athlete may be allowed to participate in non-contact activities even if their neurocognitive testing is interpreted as abnormal. The player-patient should not proceed to contact activities until their neurocognitive testing is interpreted as having returned to their baseline level by the consulting team neuropsychologist or, if a decrement persists, until the team physician has determined that this is not due to the concussion. The need and time interval for additional testing will be determined by the team physician, in consultation with the team's neuropsychology consultant, based on the clinical status of the player-patient.

Once the player-patient has demonstrated his ability to engage in cardiovascular exercise without recurrence of signs or symptoms, he may proceed to the next step.

### **Step Three: Continued Aerobic Exercise & Introduction of Strength Training**

The player-patient continues with supervised cardiovascular exercises that are increased and may mimic sport specific activities, and supervised strength training is introduced. Some may consider this step as a continuation of Step Two. If neurocognitive testing was not administered after Step One, or during Step Two, it should be administered during Step Three. If a player-patient's initial neurocognitive testing is not interpreted as back to baseline by the consulting team neuropsychologist, the tests will be repeated at a time interval agreed upon by the team physician and consulting team neuropsychologist (typically 48 hours). A player-patient may be allowed to participate in non-contact activities even if his neurocognitive testing is interpreted as abnormal. The player-patient should not proceed to contact activities until their neurocognitive testing is interpreted as back to their baseline level by the consulting team neuropsychologist or, if a decrement is still present, until the team physician has determined a non-concussion related cause. The determination of when to proceed with contact activities is ultimately made by the team physician.

Once the player-patient has demonstrated his ability to engage in cardiovascular exercise and supervised strength training without recurrence of signs or symptoms, he may proceed to the next step.

### **Step Four: Football Specific Activities**

The player-patient may continue cardiovascular conditioning, strength and balance training and participate in non-contact football activities such as throwing, catching, running and other position-specific activities. All activities at this step remain non-contact. (e.g., no contact with other players or objects, such as tackling dummies or sleds).

If the player-patient is able to tolerate all football specific activity without a recurrence of signs or symptoms of concussion and his neurocognitive testing has returned to baseline, he may be moved to the next step in the sequence.

**Step Five: Full Football Activity/Clearance**

After the player-patient has established his ability to participate in non-contact football activity including team meetings, conditioning and non-contact practice without recurrence of signs and symptoms and his neurocognitive testing is back to baseline, the team physician may clear him for full football activity involving contact. Once cleared by the team physician, the player-patient may participate in all aspects of practice. If the player-patient tolerates full participation practice and contact without signs or symptoms and the team physician concludes that the player-patient’s concussion has resolved, he may clear the player-patient to return to full participation. Upon clearance by the team physician, the player must be examined by the INC assigned to his Club. The INC must be provided a copy of all relevant reports and tests, including the player-patient’s neurocognitive tests and interpretations. If the INC confirms the team physician’s conclusion that the player-patient’s concussion has resolved, the player-patient is considered cleared and may participate in his Club’s next game or practice.

**Table 1. An Example of a Graduated Exertion Protocol\* #**

| Steps                     | Activity  | Objective   |
|---------------------------|---|---|
| 1. Rest & Recovery        | Routine daily activities as tolerated.  | Recovery  |
| 2. Light Aerobic Exercise | 10-20 minutes on a stationary bike or treadmill with light to moderate resistance supervised by the team’s athletic trainer.<br>No resistance training or weight training.<br>Duration and intensity of the aerobic | Cardiovascular challenge to determine if there are any recurrent concussion signs |

exercise can be gradually increased over time if no symptoms or signs return during or after the exercise.

or symptoms.

3. Continued Aerobic Exercise and Introduction of Strength Training

With continued supervision by the athletic trainer, increase the duration and intensity of the aerobic exercise (e.g., more intense or longer time on the bike or treadmill, introduction of running and sprinting) and introduction of non-contact sport specific conditioning drills (e.g., changing direction drills, cone drills). Introduction of strength training supervised by the athletic trainer.

Progress cardiovascular exercise, add strength training and more complex movements to determine if there are any recurrent concussion signs or symptoms.

4. Football Specific Activities

Participation in all non-contact activities for the typical duration of a full practice.

Increasing football specific demands to determine if there are any recurrent concussion signs or symptoms. Add the cognitive load of playing football.

5. Full Football Activity / Clearance

Full participation in practice and contact without restriction.

Tolerance of all football activities without any recurrent concussion signs or symptoms.

## Summary

In summary, these protocols for the diagnosis and management of concussion including preseason education and assessment, practice and game management protocols, and return to play requirements, provide a comprehensive approach to concussion diagnosis and management for the NFL player.

*\*This Table serves as a guideline. Specifics will depend on each player's situation. There is no set timeline for return to play or progression through the protocol*



[1] *Should the UNC be unavailable to participate in the sideline evaluation (i.e., UNC is treating another player in the locker room or accompanying an injured player to the hospital in accordance with the EAP), the club physician may request to conduct the assessment with the second UNC who is present on the opposing team's sideline.*

[2] *The team physician/UNC unit will be co-located for all concussion evaluations and management both on and off the field. The UNC may present his/her own questions or conduct additional testing and shall assist in the diagnosis and treatment of concussions.*

[3] *The Independent Neurological Consultant must be impartial and independent from the player's club, and be board certified or board eligible in neurology, neurological surgery, emergency medicine, physical medicine and rehabilitation, or any primary care CAQ sports medicine certified physician and has documented competence and experience in the treatment of acute head injuries (as evidenced by no less than monthly treatment of such patients). Each Club must designate one INC at the start of the league year, which must be approved by the NFL CMO and NFLPA Medical Director. For the avoidance of doubt a UNC may serve as an INC. Neither a UNC nor an INC may have any affiliation with an NFL team.*

*Note: The 2017 NFL Concussion Diagnosis and Management Protocol and the corresponding "Concussion Checklist" have been adapted from the 2017 Berlin Conference on Concussion in Sport by the NFL's Head, Neck and Spine Committee in consultation with the NFL Players Association's Mackey-White committee. The Protocol also reflects input from the NFL Physicians Society, the NFL Professional Football Athletic Trainers Society and player representatives.*

## NFL Return-To-Participation Protocol

NFL Head, Neck and Spine Committee's Concussion Protocol Overview 

# INFORMATION & RESOURCES

## **FACTS ABOUT HEAD INJURIES**

[NIH on Concussions](#)

[CDC's Brain Injury Basics](#)

## **OUR EXPERTS, ADVISORS AND COLLABORATORS**

[Chief Medical Officer](#)

[NFL Medical Committees Overview](#)

[NFL Health and Safety Committee](#)

[NFL General Medical Committee](#)

[NFL Head, Neck and Spine Committee](#)

[NFL Musculoskeletal Committee](#)

[Scientific Advisory Board](#)

[Board of Directors of Football Research, Inc.](#)

[Collaborators](#)

[The NFL Foundation](#)

## **RESOURCES FOR PLAYERS**

[CDC Concussion Poster for NFL Players](#)

[NFL Players Association Brain Health and Concussion Education Video](#)

[Protecting Feet, Ankles and Knees With Appropriate Shoes](#)

[Helmet Laboratory Testing Performance Results](#)

## **RESOURCES FOR FORMER PLAYERS**

[NFL Legends Community](#)

[NFL Player Engagement](#)

[Total Wellness](#)

[The Bridge to Success](#)

[Continuing Education Program \(CEP\)](#)

[NFL Player Care Foundation](#)

[Trust](#)

[The National Football League Alumni Association](#)

[NFL Benefits](#)

## RESOURCES FOR PARENTS AND COACHES

[CDC on Concussion in Youth Sports](#)

[CDC Parents' Guide to Concussions](#)

[CDC Concussion Poster for Young Athletes](#)

[NFHS Recommendations for Minimizing Head Impact Exposure](#)

[NFHS Concussion Course](#)

[The American Academy of Pediatrics on Tackling in Youth Football](#)

[The Korey Stringer Institute](#)

[USA Football's Heads Up Football Program](#)

[Pop Warner Health and Safety Resources](#)

[NFL Foundation Athletic Trainer Grant Program](#)

## NEWSROOM

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