March 11, 2013

The Honorable Chris Christie
Governor
State House
P.O. Box 001
Trenton, NJ 08625-001

The Honorable Stephen M. Sweeney
Senate President
State House
P.O. Box 098
Trenton, NJ 08625

The Honorable Thomas H. Kean, Jr.
Republican Leader
State House
P.O. Box 099
Trenton, NJ 08625

The Honorable Sheila Oliver
Assembly Speaker
State House
P.O. Box 098
Trenton, NJ 08625

The Honorable Jon M. Bramnick
Assembly Republican Leader
State House
P.O. Box 099
Trenton, NJ 08625

Dear Governor Christie, Senate President Sweeney, Assembly Speaker Oliver, Senate Leader Kean and Assembly Leader Bramnick:

Enclosed for your consideration is the final report of the Special Education and Traumatic Brain Injury (TBI) Task Force. The task force was established through legislation and was charged with developing best practices and processes for education professionals working with students with TBI, addressing the needs of students with TBI, studying and evaluating practices for recognizing and educating children with TBIs of all types ranging from mild to severe, preparing students with TBI for entry into college or the work force, and to examine how current statutes and regulations affect these students in order to develop recommendations to be presented to the governor and the legislature. Additionally, the task force was to examine the correlation between TBI and psychiatric illness and potential future incarceration, and to focus on recognition by all educational professionals of the signs and symptoms of mild TBI in order to promote cognitive rest, until the student recovers, to help avoid re-injury.
The task force spent a year deliberating and considering the needs of students with TBI. Recommendations were developed through a majority vote. Activities included holding monthly meetings, establishing four issues-specific sub-committees, and collecting information through public participation that consisted of conducting an online survey and sponsoring a public forum. Recommendations were voted upon by task force members. The work of the task force resulted in the attached report, entitled “Addressing the Needs of Students with Traumatic Brain Injury: Recommendations for a Plan of Action for the State of New Jersey.” The report includes a discussion of the most salient issues regarding TBI and puts forward ten recommendations for state agencies and school districts to consider when identifying, evaluating and educating students with TBI. The following table includes the ten recommendations, as well as strategies for implementation.

<table>
<thead>
<tr>
<th>Recommendation</th>
<th>Report General Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommendation 1:</td>
<td>Dedicate TBI Personnel at the State Level</td>
</tr>
<tr>
<td>Establish the positions of a TBI Education Coordinator and 4 regional TBI Education Consultants to provide training and technical assistance regarding TBI.</td>
<td>The Department of Education is reviewing current staffing patterns and meet identified needs for staff through expansion or contracted services with experts in TBI.</td>
</tr>
<tr>
<td>Recommendation 2:</td>
<td>Improve Identification of Students with TBI</td>
</tr>
<tr>
<td>Include specific questions regarding TBI on medical and school record forms and have schools and pediatricians use nationally recognized and validated TBI screening tools when a TBI is suspected, or when there is a reported history of TBI in the absence of medical documentation.</td>
<td>Pre-participation physical examination forms already include items related to head injury and concussion. The Department of Education is considering adding similar wording to the A-45 student health history and appraisal form. The NJDOE has already added links to the Department web site on reliable and validated screening tools/questionnaires; however, the Department does not endorse specific tools. The NJDOE collaborates with the American Academy of Pediatrics, NJ Chapter (AAP/NJ); however, that body would determine TBI screening recommendations for its members.</td>
</tr>
<tr>
<td>Recommendation 3:</td>
<td>Utilize District-level Staff - Roles and Training re: TBI</td>
</tr>
<tr>
<td>Involve specific school staff and specialists in the evaluation of children with TBI, for consultation and training of staff and families, and in the development of specific policies for professional development.</td>
<td>The Department of Education has increased access for school district personnel and families to information regarding best practices in the identification, evaluation and remediation of TBI.</td>
</tr>
<tr>
<td>Recommendation 4:</td>
<td>Improve Supports for Students with Concussion/Mild TBI</td>
</tr>
<tr>
<td>Expand the DOE Concussion Model Policy for monitoring all students who sustain a concussion, not just student-athletes. Include information on the need for physical and cognitive rest, as well as the use of temporary academic accommodations.</td>
<td>The NJDOE will review the Concussion Model Policy to determine the need for additional information.</td>
</tr>
<tr>
<td>Recommendation 5:</td>
<td>Improve Transition to Adult Life for Students with TBI</td>
</tr>
<tr>
<td>Provide transition planning and services to students with TBI who are identified as needing those services and include linkages to the community.</td>
<td></td>
</tr>
</tbody>
</table>
**Report General Recommendations**

We will support existing school staff in assisting students with TBI in transition planning and preparation for college and career by providing training and technical support. The NJDOE transition specialist will incorporate TBI resources for transition into future trainings and technical assistance activities.

**Recommendation 6: Ensure that TBI is Covered in Pre-service Coursework for Prospective Teachers and in Training for Disability Services Staff at Colleges**

*Programs leading to a teaching degree should include training and coursework with information about the potential educational impact of a TBI and best practices for teaching students with TBI. Improve training for disability services office staff that assist college students with TBI.*

A copy of the TBI Task Force Report will be forwarded to the Office of the Secretary of Higher Education for review.

**Recommendation 7: Increase Awareness of TBI**

*Develop a TBI (including concussion) prevention, identification, and treatment awareness campaign for educators, students, professionals and the public. Provide parents with information specific to TBI. Increase Project CHILD-FIND efforts and staff awareness of TBI.*

The Department of Human Services, the NJDOE, and the Brain Injury Alliance of New Jersey (BIANJ) will continue to collaborate on outreach activities for educators and families, including face-to-face workshops and webinars. Additional awareness activities will be considered.

**Recommendation 8: Investigate Funding Possibilities, Legislative Actions, and Interagency Collaboration**

*Explore grant opportunities to provide training for state- and school-level staff. Establish interagency boards regarding TBI.*

The NJDOE continually review opportunities for grants to improve learning for all students, including students with specific needs such as TBI. The NJDOE will explore how existing interagency boards can better reflect the needs of New Jersey citizens with TBI.

**Recommendation 9: Revise New Jersey Administrative Code (N.J.A.C.), Title 6A, Chapters 14 & 9**

*Amend and adopt a broader definition of TBI in the special education code. Amend standard seven (special needs) in the professional standards for teachers to include wording regarding students with TBI.*

The NJDOE will explore the need to amend regulations.

**Recommendation 10: Improve Services for Individuals with TBI in Psychiatric Institutions and the Juvenile Justice System and Reduce Future Incarceration**

*Increase awareness of TBI (including concussion) for educators and personnel in psychiatric institutions and juvenile justice and establish screening programs.*

The State Special Education Advisory Council includes representatives from other state agencies serving students with disabilities, including the Department of Human Services, which oversees the care of children with mental illness, and the Department of Corrections. The NJDOE will explore adding an expert in TBI to the Council.
The NJDOE recognizes the work of the task force and will collaborate with others state agencies referenced in the report to review the recommendations in the report. The work of the TBI task force will assist state agencies, through interagency collaboration, in effecting a systematic and consistent method of identification, assessment and intervention for students with TBI and a protocol for smooth hospital-to-school transition.
Addressing the Needs of Students with Traumatic Brain Injury: Recommendations for a Plan of Action for the State of New Jersey

Prepared by the New Jersey Special Education and Traumatic Brain Injury Task Force

Report Issued March 2014
Table of Contents

New Jersey Special Education and Traumatic Brain Injury Task Force Members ............ 3

Task Force Objectives ........................................................................................................ 4

Background Information on Traumatic Brain Injury in School-Aged Children .......... 5-10

Recommendations ............................................................................................................. 11-27

References and Internet Resources ................................................................................. 28-31

Glossary .............................................................................................................................. 32-33

Appendices ......................................................................................................................... 34-55

Appendix A – New Jersey Special Education and Traumatic Brain Injury Task Force -
Public Law 2009, Chapter 250 .......................................................................................... 34-35
Appendix B – State of New Jersey Health History and Appraisal Form A-45 ............ 36
Appendix C – New Jersey Brain Injury Research Act - Public Law 2003, Chapter 200 ... 37-42
Appendix D – Return to Academics Protocol after Concussion/Mild TBI (OCAMP) ...... 43
Appendix E – Sample Mild TBI/Concussion Learning Accommodations Plan (OCAMP) .. 44
Appendix F – BrainSTEPS Protocol for Returning to the Classroom ......................... 45-48
Appendix G – New Jersey Concussion Law - Public Law 2010, Chapter 94 .............. 49-51
Appendix H – New Jersey Advisory Council on TBI and the TBI Fund -
Public Law 2001, Chapter 332 .......................................................................................... 52-55
New Jersey Special Education and Traumatic Brain Injury Task Force Members

Paul Fogarty, M.Ed, CMP, Chair
Commissioner Designee
New Jersey Department of Education

Rene Carfi, LSW, CBIST, Vice-Chair
Representative 1
Brain Injury Alliance of New Jersey

Fran Leibner, MA, CCC-SLP, Secretary
Representative
New Jersey Department of Education

Malia Corde
Public Member/Assembly Speaker
Statewide Parent Advocacy Network

Connie Domingo, MD, FAAP, FAAPM&R
Pediatric Rehabilitation Professional 2
Weisman Children's Rehabilitation Hospital

Kerry Ellmer
Parent 1
Children’s Specialized Hospital, New Brunswick

Marilyn Gorney-Daley, DO, MPH
Representative
New Jersey Department of Health

Janet Gwiazda, RN, MBA
Commissioner Designee
New Jersey Department of Human Services

Linda Levine, MA, LDTC
Special Education Teacher
Howell Township Public Schools

Wallace McDowell Kyle
Representative 2
Brain Injury Alliance of New Jersey
UBS Financial Services, Inc.

Lois Mishkin, MA, CCC-SLP/LDTC
Public Member/Senate President
Lois Mishkin Associates

Harry J. Pizutelli
Representative
Department of Human Services

Joanne Plescia, PhD
Director of Special Services
Collingswood Public Schools

Joanne Ploch MA, ATC, LAT
Representative
Athletic Trainers' Society of New Jersey
Vernon Township High School

Bradford Ross, PhD
Pediatric Rehabilitation Professional 1
Children's Specialized Hospital, Mountainside
and Robert Wood Johnson-UMDNJ
Medical School

Vacant
School Social Worker

Lori A. Velasco
Parent 2
Children's Specialized Hospital, New Brunswick

Judith A. Woop, M.Ed, RN
Certified School Nurse
Adjunct Faculty
Caldwell College

With Special Thanks to:

Therese Sheehan
Former Coordinator of Educational Programs for
Students who are Deaf and Hard of Hearing
New Jersey Department of Education

Leslie M. Beres-Sochka,
Loretta Kelly, and Bretta Jacquemin
New Jersey Department of Health
Introduction

Public Law 2009, Chapter 250 established the New Jersey Special Education and Traumatic Brain Injury (TBI) Task Force (see Appendix A). The purpose of the Task Force was specified as follows:

- develop best practices and processes for education professionals working with students with TBI;
- address the needs of students with TBI;
- study and evaluate practices for recognizing and educating children with TBIs of all types, ranging from mild to severe;
- prepare students with TBI for entry into college or the work force;
- examine how current statutes and regulations affect these students in order to develop recommendations to be presented to the Governor and the Legislature;
- focus upon recognition by all educational professionals of the signs and symptoms of mild TBI in order to promote cognitive rest until the student recovers and to help avoid re-injury; and
- examine the correlation between TBI and psychiatric illness and potential future incarceration.

The task force, established in February 2012, in accordance with P.L. 2009, Chapter 250, consisted of 18 members as follows: designees of the Commissioners of Education and Human Services, who served ex officio; and 14 persons appointed by the Governor, who included: one representative of the Department of Education, one representative of the Department of Human Services, one representative of the Department of Health and Senior Services, two representatives of the Brain Injury Association of New Jersey, two parents of children who have suffered a traumatic brain injury, two pediatric rehabilitation professionals with knowledge of traumatic brain injury, one school social worker, one school nurse, one special education teacher, one director of special education services for a school district, and one representative of the Athletic Trainers’ Society of New Jersey; and two members of the public, one selected by the President of the Senate and one selected by the Speaker of the General Assembly, with demonstrated expertise in issues relating to the work of the task force.

The task force spent a year deliberating and considering the needs of students with TBI. Recommendations were developed through a majority vote. Activities included holding monthly meetings, establishing four issues-specific sub-committees, and collecting information through public participation that consisted of conducting an online survey and sponsoring a public forum. Recommendations were voted upon by task force members. The work of the task force resulted in the attached report, entitled “Addressing the Needs of Students with Traumatic Brain Injury: Recommendations for a Plan of Action for the State of New Jersey.” The report includes a discussion of the most salient issues regarding TBI and puts forward ten recommendations for state agencies and school districts to consider when identifying, evaluating and educating students with TBI. The following table includes the ten recommendations, as well as strategies for implementation.
Background Information on Traumatic Brain Injury in School-Aged Children

Since 1998, the New Jersey Administrative Code for Special Education (N.J.A.C. 6A:14) has included Traumatic Brain Injury (TBI) as a disability category for determination of eligibility for special education and related services, in conformance with the federal definition under the Individuals with Disabilities Education Act (IDEA). Traumatic Brain Injury, under N.J.A.C. 6A:14-3.5(c)13, is defined as “... an acquired injury to the brain caused by an external physical force or insult to the brain, resulting in total or partial functional disability or psychosocial impairment, or both. The term applies to open or closed head injuries resulting in impairments in one or more areas, such as cognition; language; memory; attention; reasoning; abstract thinking; judgment; problem-solving; sensory, perceptual and motor abilities; psychosocial behavior; physical functions; information processing; and speech.”

For special education eligibility, it must also be determined that a disability adversely affects educational performance and the student needs special education and related services in order to access and progress in the general education curriculum. Students with TBI may or may not qualify for special education and related services; however schools may also support these students by providing temporary academic accommodations, individualized health care plans or, if eligible, Section 504 accommodation plans (see definitions listed in the Glossary). As the educational system is responsible for identifying, assessing, and teaching students with TBI, it is likely that most educators will encounter students with TBI at some point in their career. The ability of educators and other school personnel to appropriately identify, assess, and educate these students has a critical impact upon their lives.

The Silent Epidemic

Traumatic brain injury is called the “silent epidemic” because the complications that result from TBI are often not visible. Additionally, there is a lack of awareness of what TBI means and how it impacts day-to-day life, despite the staggering number of people who are injured each year. According to the Centers for Disease Control and Prevention (CDC), as many as 1.7 million people in the United States sustain TBIs each year, with 80% resulting in emergency department visits, 16% resulting in hospitalizations, and 3% resulting in death.

Often what is really a traumatic brain injury is diagnosed as a behavioral or learning problem. Thus, the “silent epidemic” includes thousands of undiagnosed brain injuries.

While the effects can include obvious physical difficulties, most are invisible to the naked eye and affect cognition, emotions, and behavior. The educational implications and the effects of the TBI vary and may not be apparent initially. The majority of children who have mild or moderate TBI may not be hospitalized or even seek medical attention. This means that many children and their families are not aware that a child has sustained a brain injury and may need special attention. Family members, school personnel, and even medical professionals may have trouble figuring out why a child’s behavior or abilities have changed when symptoms or effects finally appear. Various effects of a brain injury are listed on Table 1 on the following page.
Traumatic brain injury (TBI) is a leading cause of death and disability among children and young adults in the United States. (CDC, 2010)

Table 1
Effects of Traumatic Brain Injury

<table>
<thead>
<tr>
<th>Cognitive Effects</th>
<th>Physical Effects</th>
<th>Psychosocial Effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Attention and concentration</td>
<td>• Seizures</td>
<td>• Anxiety</td>
</tr>
<tr>
<td>• Communication skills</td>
<td>• Muscle spasticity</td>
<td>• Depression</td>
</tr>
<tr>
<td>• Information processing</td>
<td>• Fatigue</td>
<td>• Mood swings</td>
</tr>
<tr>
<td>• Visual processing</td>
<td>• Sleep disturbances</td>
<td>• Impulsivity and disinhibition</td>
</tr>
<tr>
<td>• Memory</td>
<td>• Headaches</td>
<td>• Irritability</td>
</tr>
<tr>
<td>• Executive functioning</td>
<td>• Balance problems</td>
<td>• Social isolation</td>
</tr>
<tr>
<td>o Organization</td>
<td>• Speech difficulties</td>
<td>• Aggression</td>
</tr>
<tr>
<td>o Reasoning and abstract thinking</td>
<td>• Loss of range of motion</td>
<td>• Emotional lability</td>
</tr>
<tr>
<td>o Problem solving</td>
<td>• Visual difficulties</td>
<td>• Blunted affect</td>
</tr>
<tr>
<td>o Decreased self-awareness</td>
<td>• Loss of sense of smell and taste</td>
<td>• Loss of self-esteem</td>
</tr>
<tr>
<td></td>
<td>• Hearing problems</td>
<td>• Difficulty establishing and maintaining relationships</td>
</tr>
<tr>
<td></td>
<td>• Paralysis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Motor control and coordination</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Sensory overload</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Decreased tolerance for alcohol and drugs</td>
<td></td>
</tr>
</tbody>
</table>

Traumatic brain injury is also “silent” because most children with TBI appear the same as their peers. Some difficulties may not become apparent until the student reaches a developmental stage requiring more complex abilities. Impairments from an earlier TBI become evident with new learning or decision-making requiring higher level executive functioning. As a child tries to learn new and more complex information in school, or make complicated and important moral decisions, difficulties may appear over time, even years after the injury. For children with severe TBI, the advent of new medical technologies has greatly increased survival rates, resulting in their return to home and school. By better understanding the needs of students with TBI, educators can help them improve not only their learning, but also their social and emotional functioning.

**Traumatic brain injury (TBI) is a leading cause of death and disability among children and young adults in the United States.** (CDC, 2010)

Traumatic brain injuries occur during everyday activities. Among young children, the most common causes are falls, such as a fall from a changing table or down the stairs. Tragically, physical abuse by hitting or shaking a child is another major cause in young children. Car crashes, where the child is a passenger or is struck by a car, are major causes of brain injury among all ages. Falls or collisions while skate boarding, rollerblading, or biking, as well as sports injuries, are common causes of TBI in elementary school-age children and adolescents.
TBI Statistics for Children and Young Adults

- According to statistics from the CDC, in the United States, almost half a million emergency department visits for TBI are made annually by children aged 0 to 14 years.
- Very young children aged 0 to 4 years have the highest rate of TBI-related emergency visits, followed by older adolescents aged 15 to 19 years.
- Males aged 0 to 4 years have the highest rate of TBI-related emergency department visits, hospitalizations and deaths combined, with rates also high for females aged 0 to 4, and for both males and females aged 15 to 19 years.
- Data from the New Jersey Department of Health (DOH), Center for Health Statistics, for the year ending in 2011, indicated that 1,346 children and youth aged 0-21 were hospitalized with TBI and an additional 34,880 were seen in emergency departments (ED). As per Table 2 below, there is an overall decrease in hospitalizations from 2000-2011 for 0-21, but an increase in ED visits (from 2007-2011). Hospitalizations for children aged 0-2 years have some fluctuation, but not an obvious trend. Emergency department visits for all four age groups have increased, while hospitalizations for age groups 3-21, 0-17, and 18-21 have decreased.

<table>
<thead>
<tr>
<th>Age Groups</th>
<th>0-21 Years</th>
<th>0-2 years</th>
<th>3-21 years</th>
<th>0-17 years</th>
<th>18-21 years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year of Discharge</td>
<td>Hosps ED visits</td>
<td>Hosps ED visits</td>
<td>Hosps ED visits</td>
<td>Hosps ED visits</td>
<td>Hosps ED visits</td>
</tr>
<tr>
<td>2000</td>
<td>1871</td>
<td>279</td>
<td>1592</td>
<td>1318</td>
<td>553</td>
</tr>
<tr>
<td>2001</td>
<td>1797</td>
<td>258</td>
<td>1539</td>
<td>1237</td>
<td>560</td>
</tr>
<tr>
<td>2002</td>
<td>1717</td>
<td>265</td>
<td>1452</td>
<td>1230</td>
<td>487</td>
</tr>
<tr>
<td>2003</td>
<td>1778</td>
<td>270</td>
<td>1508</td>
<td>1271</td>
<td>507</td>
</tr>
<tr>
<td>2004</td>
<td>1696</td>
<td>251</td>
<td>1445</td>
<td>1194</td>
<td>502</td>
</tr>
<tr>
<td>2005</td>
<td>1713</td>
<td>276</td>
<td>1437</td>
<td>1210</td>
<td>503</td>
</tr>
<tr>
<td>2006</td>
<td>1774</td>
<td>295</td>
<td>1479</td>
<td>1188</td>
<td>586</td>
</tr>
<tr>
<td>2007</td>
<td>1738</td>
<td>26605</td>
<td>281</td>
<td>6481</td>
<td>1457</td>
</tr>
<tr>
<td>2008</td>
<td>1611</td>
<td>26659</td>
<td>290</td>
<td>6478</td>
<td>1321</td>
</tr>
<tr>
<td>2009</td>
<td>1570</td>
<td>35115</td>
<td>327</td>
<td>8432</td>
<td>1243</td>
</tr>
<tr>
<td>2010</td>
<td>1555</td>
<td>33567</td>
<td>334</td>
<td>7858</td>
<td>1221</td>
</tr>
<tr>
<td>2011</td>
<td>1346</td>
<td>34880</td>
<td>281</td>
<td>7988</td>
<td>1065</td>
</tr>
</tbody>
</table>

These were all patients discharged ALIVE from the hospital or emergency department.

Source: New Jersey Hospital Discharge Data System, 2000-2011
Center for Health Statistics,
Office of Policy and Strategic Planning
Office of the Commissioner
New Jersey Department of Health
January 4, 2013
Despite these documented incidences of TBI in school-aged children in New Jersey, 2012 data from the New Jersey Department of Education (DOE) indicated only 767 students ages 5-21 classified as eligible for special education and related services under the disability category TBI. These data reflect a high incidence, yet low TBI classification rate. It is also probable that additional students with TBI are classified under one of the other disability categories at N.J.A.C. 6A:14-3.5(c) and that some receive accommodations under a Section 504 plan.

Nationally, undercounting of TBI was noted by a majority of states in a 2012 survey of 43 directors in the National Association of State Directors of Special Education (NASDSE) conducted by the Center on Brain Injury Research and Training (CBIRT). According to their survey summary report, “Factors contributing to the inaccuracy were: a) lack of awareness about TBI as a disability (e.g., educators didn’t understand the long-term consequences of TBI), b) lack of communication between hospital and school, c) identification of students with TBI under different eligibility categories, d) under-reporting of injuries by parents, and e) a narrow definition of TBI that excludes other forms of acquired brain injury (stroke, tumor, surgery, etc.). Lack of awareness included both parents’ and professionals’ unfamiliarity with characteristics of students with brain injury, definitions used by schools, and the consequences of brain injury on school performance. The most frequently suggested steps to address the inaccuracy were a) professional development (workshops, web resources), b) mandatory in-school screening, and c) improved reporting and communication from medical personnel…”

Because no two students with TBI present exactly the same profile, providing appropriate programs and supports are a challenge for everyone involved. By helping these students to use their strengths, compensate for their weaknesses, and develop new skills, educators and school staff with training in TBI can enhance learning, independence, and productivity for all students with TBI in the educational system.

Levels of TBI

Traumatic brain injuries are characterized as mild, moderate, and severe. It should be noted, however, that severity of TBI may not predict outcome. Although definitions vary, the following guidelines describe these terms which are often used in medical reports:

- **Mild TBI** occurs when there is brief (less than an hour) or no loss of consciousness. A concussion is considered a mild traumatic brain injury (MTBI). The Glasgow Coma Scale (GCS) score is 13 to 15 for MTBI.
- **Moderate TBI** occurs when there is loss of consciousness lasting more than 1 hour but less than 24 hours, the neurological evaluation finds evidence of brain trauma, and there are possible positive findings on a computerized tomography (CT) scan or electroencephalography (EEG). The GCS score is 9 to 12 for moderate TBI.
- **Severe TBI** occurs when there is loss of consciousness lasting more than 24 hours and the GCS score is 3-8. There is usually structural and metabolic brain dysfunction and individuals with severe TBI are at high risk of secondary brain injury and deterioration.
What are the symptoms and effects of MTBI?

The majority of TBIs that occur are mild. In many cases, the student returns home from the hospital, or is never admitted at all, and goes back to school without any rehabilitation. Students with MTBI are more likely to remain in general education classrooms when they return to school, with or without accommodations. Neurophysiological or neuroimaging tests can confirm organic brain damage in moderate or severe TBI, and this helps identify those students; however, there is often no such identification when the injury is a mild one. Students with MTBI may not seek or receive medical attention and if any neurophysiological or neuroimaging tests were performed, the results are often negative. The student and family are often told that there is “no problem” and there is no reason for further evaluation.

Many children have blows to the head in the course of their normal play and development. While the majority of these do not result in any lasting effects, there is evidence that MTBI can result in cognitive, physical, and behavioral changes. The persistence of these changes is a direct consequence of organic brain damage despite the mild degree of injury. In most cases, students are told to rest, take medication for headaches, and return to school within a few days. Some may return in as little as a day. Upon returning to school, students may not be aware of any cognitive changes. However, they may have decreased school performance and develop behavioral problems that did not exist prior to the injury.

Following MTBI, the student may complain of headaches, dizziness, physical and cognitive fatigue, problems with processing language, memory problems, concentration difficulties, and poor judgment. These can affect classroom work and interpersonal relationships. The teacher is often the first person to notice changes in a student that may be the result of MTBI. The next critical step is to communicate this information to the family and support systems within the school.

Recovery or progress after MTBI can be hindered by preexisting conditions that include: learning disabilities, personality disorders, substance abuse, impulsivity, and attention deficit disorders. These conditions are likely to alter outcomes for a student with any degree of TBI.

What happens after a moderate or severe TBI?

The path of treatment and rehabilitation for a student with moderate to severe TBI usually begins with the emergency department and often moves to inpatient care at a local hospital or trauma center. This may be followed by transfer to an inpatient rehabilitation hospital and then to outpatient rehabilitation when the student finally returns home. A typical day in the rehabilitation hospital includes cognitive, speech/language, physical, and occupational therapies, plus psychosocial support services.

Some inpatient rehabilitation programs have a hospital-based school program with a special education teacher. This is sometimes the first academic experience that the student has following TBI and it serves as a baseline for cognitive and academic functioning. For those
students who have been hospitalized and are now living at home again, rehabilitation therapies may still be needed. Multiple demands such as catching up on missed schoolwork, homework, outpatient or home therapy programs, and returning to normal daily activities can cause physical and cognitive stress that may inhibit the healing process from TBI.

The initial return to school is just the beginning. Educators are critical players and resources on this journey as it continues over time.

With rehabilitation and the support of family, friends, and the community, many students with TBI are able to resume pre-injury activities. Recovery may take weeks, months, or years. Students with moderate or severe TBI often require special education programs and related services from their school district, which may be provided in an array of options ranging from support in general education classes to pull-out resource center programs, special classes, or, in some cases, out-of-district placements.

Often, recovery is slow and incomplete. Factors that affect recovery include, but are not limited to:

- age when injured;
- time-lapsed since the injury;
- length of coma, if any, and presence of post-traumatic amnesia;
- cause, location, and severity of injury;
- severity and duration of symptoms, including physical, cognitive and emotional/behavioral;
- history of previous TBI;
- personality and/or behavioral characteristics prior to injury;
- intellectual and functional levels prior to injury;
- support systems;
- environment and treatment since the injury;
- depression or other mental health disorders;
- migraines or sleep disorders; and
- overall medical health.

“The issues facing children with brain injury are vast and complex; therefore the response and approach to support them needs to be equally comprehensive.”

(Dettmer, Ettel, Glang and McAvoy, 2013).
Recommendations

The recommendations that follow are in response to the purposes of the Task Force noted in the Task Force Objectives on page 5 and specified below:

- develop best practices and processes for education professionals working with students with TBI;
- address the needs of students with TBI;
- study and evaluate practices for recognizing and educating children with TBIs of all types, ranging from mild to severe;
- prepare students with TBI for entry into college or the work force;
- examine how current statutes and regulations affect these students in order to develop recommendations to be presented to the Governor and the Legislature;
- focus upon recognition by all educational professionals of the signs and symptoms of mild TBI in order to promote cognitive rest until the student recovers and to help avoid re-injury; and
- examine the correlation between TBI and psychiatric illness and potential future incarceration.

The foremost recommendation is: **the establishment of a TBI Education Coordinator within the DOE and the establishment of four Regional TBI Education Consultants.** The Task Force’s rationale is that national research on building capacity of educators to serve students with TBI recommends a regional team approach based out of, or in partnership with, a state education agency.

Several states, among them Colorado ([http://cokidswithbraininjury.com/](http://cokidswithbraininjury.com/)) and Pennsylvania ([http://www.brainsteps.net/](http://www.brainsteps.net/)), have established models and have been working together to develop best practices for addressing the needs of students with TBI based on this model. In fact, a recent national “Summit on Childhood Brain Injury” identified professional development for school personnel as a key component for building statewide infrastructure for effective educational services for students with TBI. Their consensus paper identified the following recommendations regarding professional development practices: 1) evidence-based training content; 2) hands on training (citing that information and indirect training alone is unlikely to result in changes in classroom practice); 3) consultation in the classroom (of sufficient duration, 7-8 sessions, to produce long-term sustained use of new strategies in the instructional setting); and 4) ongoing organizational support. As such, providing general information about students with TBI through booklets, in-services, and webinars alone is not enough, necessitating the establishment of more intense support that a TBI Education Coordinator and four Regional TBI Education Consultants could provide. This recommendation and the others that follow will allow implementation of effective services for students with TBI.
Recommendation #1: Dedicate TBI Personnel at the State Level

❖ Establish a TBI Education Coordinator within the DOE

The responsibilities of the TBI Education Coordinator would include the following:

- Develop a comprehensive statewide network of Regional TBI Education Consultants, ensuring each of the four regions (northeast, northwest, central, and southern) has expertise within the school districts to provide technical assistance related to serving students with TBI;
- Provide coordination, training, and technical assistance for the four Regional TBI Education Consultants;
- Develop a systematic and consistent methodology for the identification, assessment, and intervention of students with TBI;
- Implement a hospital-to-school transition protocol, incorporating a partnership between school districts and hospitals;
- Facilitate the identification and transition of youth with MTBI through the implementation of a return to the classroom model for students following concussion;
- Assist in the development of mechanisms to collect accurate data on TBI incidence in children; and
- Implement an evaluation plan for program effectiveness.

❖ Establish Four Regional TBI Education Consultants

The responsibilities of the four Regional TBI Education Consultants would include the following:

- Work with the TBI Education Coordinator to develop an annual capacity building/training plan for the state of New Jersey to build the capacity of local school districts to effectively support children and youth with TBI;
- Develop an integrated system of supports for school-aged children with TBI, to ensure that the student’s education, health, and community needs are met and to enable the student to progress sequentially and deliberately towards the achievement of postsecondary goals;
- Build capacity to serve students at the district level and assist in developing district-based Brain Injury Resource Teams (BIRT). These would include designated school staff to serve as the contact person for students with concussion or moderate to severe TBI, determined on an individual student basis, in partnership with families;
- Work with the TBI Education Coordinator to develop a hospital transition protocol by incorporating a partnership between school districts and hospitals;
- Work with the TBI Education Coordinator to implement a return to the classroom model for students with concussion;
- Follow students with TBI from age three through high school, coordinating and facilitating all educationally related transitions for students with TBI; and
- Provide coordination, training, and technical assistance for the school districts in the region to assist all school and district personnel, families, and community supports involved with the student with TBI.
Equally important to providing supports and services for students with TBI is the issue of identification. As was previously pointed out, under-identification and misidentification of students with TBI is a primary issue nationally. While children and adolescents with TBI are being identified by the healthcare system as having sustained a brain injury, there is a breakdown between the healthcare system and the educational system in identifying these students as having a brain injury.

There are multiple reasons for identification discrepancies, including, but not limited to:

Some parents may be apprehensive about identifying and classifying their child as having sustained a brain injury.

- The effects of the injury may be latent – “A child’s brain continues to develop until he or she reaches his or her early 20s… The full impact of an injury on a child’s brain becomes evident over time as the brain fails to mature in line with the child’s physical growth and development… These delayed or latent effects can create lifetime challenges for living and learning for children, their families, schools and communities…” (DePompei and Bedell, 2008).

- Effects of brain injury may mimic other disabilities that may lead to misdiagnosis and inappropriate placement. The student who has attention and concentration issues may be labeled attention deficit hyperactivity disorder. Those who exhibit impulsivity and disinhibition may be labeled oppositional defiant disorder and individuals with multiple physical impairments may be classified as multiply disabled. A recent online survey of parents by the Brain Injury Alliance of New Jersey (BIANJ) found that while 46% of parents reported that their child was classified under the TBI disability category, the remaining 54% had children classified under a variety of categories, including Other Health Impaired, Cognitively Impaired, Specific Learning Disability, Multiply Disabled, Communication Impaired, Auditorily Impaired, Emotionally Disturbed, Orthopedically Impaired, Autistic, Visually Impaired and Deaf/Blindness.

- Under-identification and misidentification may occur within the educational system.

While there is a heightened awareness of concussion, there is still a general lack of awareness of TBI and its effects. The discrepancy between those identified by the healthcare system (for ages 3-21: 27,957 in one given year) and those classified under the category of TBI (for ages 5-21: 767) is significant. Therefore, as per national findings and the recommendations of this Task Force, improving identification through screening tools, a TBI registry, and other means is imperative.

**Recommendation #2: Improve Identification of Students with TBI**

- **Incorporate questions about history of TBI, including concussions, in school medical records**

  - Specific items dealing with concussions and head trauma should be included in the forms required for entrance into school and for participation in interscholastic sports, and these records should be updated annually. The DOE and/or school districts should amend the first page of the A-45 student health history and appraisal form (see Appendix B) to include items specifically related to TBI and concussion/MTBI.
Incorporate the use of a nationally recognized and validated TBI screening tool and relevant questionnaires in all cases of a suspected (unidentified) or reported history of TBI in the absence of medical documentation

- The previously referenced “Summit on Childhood Brain Injury” identified three reliable and validated screening and structured interview tools developed to assess students suspected of having had a prior brain injury: the Brain Check Survey, a free tool, (http://cokidswithbraininjury.com/ckwbi/wp-content/uploads/2009/11/Brain-Check-Survey-10-02-091.pdf), the Brain Injury Screening Questionnaire [BISQ] (information available at: http://www.mssm.edu/research/centers/brain-injury-research-center-of-mount-sinai/resources/technical-assistance/brain-injury-screening), and the Ohio State University TBI Identification Method [OSU TBI-ID] (http://tbinetwork.org/about-tbi/screening/). The report also identified key components of TBI screening, including (a) staff with foundational knowledge of TBI, (b) screening and structured interview, and (c) focused assessments.

- Each school within a district should identify appropriate school professionals who would implement the TBI screening tools. Such professionals could include, but would not be limited to the school nurse, guidance counselor, CST member, BIRT member, 504 team, I & RS team, teacher, and/or or athletic trainer (if applicable). School staff needs to know that the student with TBI may exhibit physical, mental, behavioral, and/or emotional changes in the classroom setting. Changes that are observed should be documented, the student’s parents should be contacted, and a medical referral suggested.

Work with the American Academy of Pediatrics, New Jersey Chapter (AAP/NJ) to improve awareness and identification of students with TBI

- Incorporate questions regarding brain injury into the existing developmental screening tools and/or encourage the use of a nationally recognized TBI screening during pediatric visits. The TBI Education Coordinator and TBI Regional Educational Consultants should also collaborate with AAP/NJ to work to improve awareness and identification of students with TBI as well as establish best practices to address the educational needs of students with TBI upon their return to school.

Strengthen the existing Central Registry (established in the DOH and maintained by New Jersey State Commission on Brain Injury Research) of persons who sustain brain injuries, as mandated by the Brain Injury Research Act, P.L. 2003, c. 200 (See Appendix C - section C.52:9EE-8)

- The current Central Brain Injury Registry should be supported with resources as appropriate to provide a database that indicates the incidence and prevalence of brain injuries. It should serve as a resource for research, evaluation, and information on brain injuries and available services. Children aged 0-21 who are registered should be afforded access to information, available services and resources, including case management services, which are provided through the Birth Defects and Autism
registries, also established within the DOH. This would result in provision of information to parents regarding educational and health services and resources for students with TBI.

- **Allocate funding for any needed resources to strengthen the current Brain Injury Registry or enable linkage or integration with other registries**
  
  - Funding could be considered from the New Jersey Brain Injury Research Fund, established pursuant to section 9 of P.L.2003, c.200 in the Department of the Treasury.

- **Designate a contact person at the DOH to ensure children identified with TBI are linked to information, resources, and county case management services**
  
  - Children with TBI who are registered should be able to access the statewide county case management system where children with special health care needs and their families can be referred to appropriate medical, dental, rehabilitative, social, emotional, and economic resources for care and treatment. A contact person at the DOH could also collaborate with designated staff at the DOE and the Department of Human Services (DHS) to ensure appropriate registrations, linkage, and referral for services.

- **Establish a referral process for hospitals and physicians, with the TBI Education Coordinator serving as a single point of contact**
  
  - Based on the Student Transition and re-Entry Program (STEP) model currently implemented in Colorado, Ohio, and Oregon (http://www.cbirt.org/our-projects/school-transition-re-entry-program-step/), it is recommended that the DOE TBI Education Coordinator serve as a single point of contact for all hospitals and doctors’ offices. The TBI Education Coordinator would then inform a Regional TBI Education Consultant who would, in turn, notify the school and offer resources and support to the school and family. School staff would be able to access training and support, as needed, from the regional consultant, and parents would be able to call the regional consultant at any time.

**Recommendation #3: Utilize District-level Staff - Roles and Training re: TBI**

- **Child Study Team (CST) members and related services providers (e.g., speech-language specialists, physical therapists, occupational therapists, school nurses, counselors, behavioral specialists, etc.) should be utilized in supporting students who are experiencing cognitive changes, physical problems, social-emotional issues, and/or academic difficulties secondary to TBI**
  
  - Whether the student is receiving temporary accommodations, is referred for a CST evaluation, I&RS, or to the Section 504 Coordinator, consultation and training should be provided to the school staff. TBI impacts various aspects of learning: math,
language and related areas of reading, spelling and written language, pragmatics, word retrieval, expression, memory, higher order and abstract thinking, attention, and concentration. The identified specialists (e.g. team members of the BIRT) should assist in the review of medical assessments previously conducted and/or in decision-making regarding the need for additional referrals and consultation for TBI-related issues involving hearing and/or visual difficulties, oral-motor deficits, speech and language, literacy/language arts, assistive technology, cognitive skills, and behavior/social skills. A neuropsychological, psychological, or psychoeducational evaluation that addresses the impact of the TBI and identifies cognitive strengths and weaknesses should be considered as part of a multidisciplinary assessment. Additionally, a comprehensive speech-language evaluation should be considered if communication/language impairment is suspected.

- **Districts should develop policies and related procedures for working with students with TBI, including guidelines that address staff training/professional development, in accordance with current and any amended regulations at N.J.A.C. 6A:9-15**

  - Teachers of students who have been identified with TBI should receive training in supporting these students in the classroom setting. School districts are encouraged to provide this training in collaboration with the Regional TBI Education Consultants and BIANJ, and to also utilize online education courses such as the Brain Injury Primer currently offered at no cost by Rutgers University (see information at: [https://ce-catalog.rutgers.edu/courseDisplay.cfm?schID=53688.](https://ce-catalog.rutgers.edu/courseDisplay.cfm?schID=53688.)).

  - It is recommended that school districts use a team approach when developing strategies and techniques to be implemented by school staff involved in the education of a student affected by TBI. Additionally, sample protocols and checklists specific to TBI should be available for school personnel (e.g., developed by the school’s BIRT or provided through technical assistance from the Regional TBI Education Consultant).

- **Designate a professional who has been trained and understands TBI (e.g., BIRT member) to assist in transitioning students with TBI to, from, and within the school district and to collaborate with the CST case manager, district transition specialist, if applicable, and Regional TBI Education Consultant**

  - Transitions of all types present challenges for students with TBI as adjustment to a new environment with a new set of structures and directions places a demand on cognitive and executive functioning skills. The transition from hospital/rehabilitation center to school can be eased by having designated school staff meet with student, family and rehabilitation staff and observe the student in the medical setting to assist in planning the return to school. These individuals should work with the Regional TBI Education Consultant and the school-based team (e.g., BIRT, CST, 504), as applicable, to coordinate the return to school.
• They should also assist with the transition of students with TBI, including MTBI, from one grade or school building to another and from high school to postsecondary education or employment. The designated school staff should provide training to relevant high school staff (e.g., BIRT, CST members, guidance counselors, teachers, etc.), on a case-by-case basis, to enable them to work effectively with students with TBI.

❖ School districts should provide social supports for students with TBI

• It is not uncommon for students with brain injury to experience psychosocial changes (e.g., social isolation, behavioral challenges, etc.) that affect their ability to interact appropriately with their peers. As various types of social support programs and services exist within the educational system (e.g., social skills groups, peer mentoring, counseling, etc.), it is recommended that they be considered for students experiencing psychosocial changes after TBI. It is also recommended that training regarding TBI, and resultant psychosocial issues, specifically, be provided to school personnel responsible for implementing the social supports.

Recommendation #4: Improve Supports for Students with Concussion/MTBI

❖ Revise the DOE Concussion Model Policy to include expanded guidelines for monitoring a student’s return to the classroom following concussion

• The current DOE guidelines related to concussion should be expanded and modified to include information from the following protocols: the Oregon Concussion Awareness and Management Program (OCAMP) developed by CBIRT in collaboration with the Oregon Department of Education (see two sample forms in Appendices D and E and the entire OCAMP guidebook online at http://www.cbirt.org/media/dynamic/2011/08/Sports_Concussion_Management_Guide.pdf), and Pennsylvania’s BrainSTEPS protocol for returning to the classroom after a concussion (see Appendix F and online at http://www.brainsteps.net/_orbs/about/2_BrainSTEPS_Protocol.pdf).

• Even when a student-athlete has recovered enough from MTBI to return to the classroom, the injury may still affect thinking, memory (especially for new information), and organizational skills. Parents and educators should understand the need for both physical and cognitive rest at this critical time in the recovery process. It is also important to keep in mind that problems with short-term memory, concentration, organization, and mental stamina can temporarily turn a good student into a poor student. While these students may not sustain a disability that would require a 504 Plan or an Individualized Education Program (IEP), they may benefit from temporary academic accommodations.

• The school administration, school nurse, guidance counselor and/or athletic trainer, and teacher should provide input, along with the physician, in regard to managing the student’s return to physical and cognitive activities within the school environment.
This should be completed after reviewing the school’s Concussion Policy, as per New Jersey’s Concussion Law, P.L. 2010, Chapter 94 (See Appendix G) which states: “Each school district shall develop and implement, by the 2011-2012 school year, a written policy concerning the prevention and treatment of sports-related concussions and other brain injuries among student-athletes. The policy shall include, but need not be limited to, the procedure to be followed when it is suspected that a student-athlete has sustained a concussion or other brain injury.”

- Initial guidelines for all students who sustain MTBI, not just student-athletes, should include the following:
  - **Discourage use of technology**: Students should eliminate or reduce time spent text messaging, playing video games, watching television and movies, and working on a computer.
  - **Attendance**: Students should avoid coming to school until they are physically able to withstand the rigor of the school day. Once they are able to return, they may need to attend on a half-day basis, progressing to full days once able to do so without exacerbating symptoms. Frequent rest breaks may be needed throughout the day if symptoms increase. Students may be granted early dismissal from classes to avoid crowded hallways.
  - **Workload**: It may be necessary to initially eliminate or significantly reduce, not just postpone a student’s academic workload. This may include a reduction in classwork, homework, and projects. In addition, educators may need to assist students with their coursework. It should be stressed that educators may need to eliminate assignments all together in order to prevent the student’s workload from becoming insurmountable during the recovery phase from MTBI.
  - **Note taking**: Students should initially be provided with notes and/or outlines prior to class discussion. Previewing/pre-reading material (especially for courses with a large lecture component) will aid in student comprehension of the material as presented in class.
  - **Extra Time**: Extra time may be necessary for tests, quizzes, and written assignments both at home and during the school day.
  - **Excused from Physical Education**: Students should not participate in physical education classes until medically cleared by a physician.

- Best practices for temporary academic accommodations for students without an IEP or a 504 plan include the following:
  - When a parent, school nurse, or athletic trainer refers a student to a physician for a suspected concussion (MTBI), the physician may recommend temporary academic accommodations for the student that are short in duration and do not require a 504 plan or IEP. Since cognitive rest is recommended for individuals suffering from MTBI, these accommodations need to be put into place immediately to allow these signs and symptoms to subside. In this case, the school nurse or athletic trainer should forward the accommodations to the school guidance counselor or appropriate designated school staff. These school staff members should receive training in return to the classroom procedures (See Appendices D and F).
The designated individual should then notify each of the student’s teachers who must implement the plan as per the physician’s recommendations.

**Recommendation #5: Improve Transition to Adult Life for Students with TBI**

- Provide high quality transition planning and transition services to students with TBI who are identified as needing those services, to improve transition to postsecondary education and to prepare them for college and career.

- Students with TBI who desire postsecondary education for college and career should receive specific guidance and planning from the school, whether or not they have IEPs. The goal of the transition process, which is a required component of an IEP for students who are classified, is to plan for life after high school. As such, transition services are specified for those students ages 16 and older under IDEA (see the box on the following page) and beginning at age 14 under the State’s special education regulations. It is the Task Force’s recommendation that the elements of transition planning/services required for students classified as eligible for special education and related services be considered for all students with TBI, and provided to any identified as needing those services.

- Although there are several postsecondary options available for students with TBI, including employment, training programs, supported employment, two- or four-year college, military or vocational programs, these can often be overwhelming for the student and family. Designated school personnel (e.g., CST case manager, transition specialist, guidance counselor, teacher, etc.), in collaboration with the BIRT, CST, and Regional TBI Education Consultant, as applicable, should be knowledgeable about the student’s current levels of functioning.

These areas include, but are not limited to the following:
- academic strengths/weaknesses and student’s insight into these;
- independence - physical and emotional;
- need for ongoing services in college - rehabilitation and/or academic supports;
- ability to self-advocate;
- necessary accommodations;
- need for assistive technology; and
- levels of initiation and motivation (as affected by the injury).
As community participation and experiences are included in the above listed transition services, it is important to consider a linkage to the community in which the student will reside. Community activities and resources are significant ways for the student to develop relationships. Such connections can lead to community-based instruction and other work experiences for high school students with TBI and will help prepare them for employment positions and inclusion into the community.

For one to become involved in the community, the designated school staff should connect the student with the following, as identified by Condeluci (1994):

- Community Colleges;
- Local 4-year colleges and universities;
- Clubs and associations - video clubs, computer clubs;
- Noncredit classes at a local school;
- Groups providing a service - church, Lions, social groups;
- “Y” programs; and
- Local employment agencies.

Additionally, the following areas should be addressed in regard to community integration:

- Legal;
- Recreational/leisure activities and appropriate behaviors;
- Transportation;
- Medical;
- Living environment; and
- Financial and personal/family needs.
The school staff, student and family should work together for appropriate high school experiences and postsecondary educational placements. Connections to community-based groups, services organizations, civic groups, and community events should be encouraged to allow students with TBI to use their abilities and not be viewed solely as a student with a disability. College bound students with TBI may need assistance from designated staff knowledgeable about student support services and financial aid at the recommended colleges for students with disabilities. Staff should guide the student with TBI through the application process, monitoring all aspects and helping as needed, especially with deadlines.

Recommendation #6: **Ensure that TBI is Covered in Pre-service Coursework for Prospective Teachers and in Training for Disability Services Staff at Colleges**

- The Office of the Secretary of Higher Education should review the education programs/curricula of New Jersey’s colleges and universities to ensure that all teachers understand the concepts of TBI and the appropriate learning strategies for making the subject matter meaningful to students with TBI.

- All higher education programs leading to a teaching degree should include training and coursework that contains information specific to symptoms of TBI, its potential educational impact, and the best practices in regard to teaching students with TBI. This would include modifying instruction to accommodate the special learning needs of students with TBI, consistent with the professional standards for teachers specified in N.J.A.C. 6A:9.

- Colleges and universities should provide training for staff in their offices of disability services to increase awareness of TBI and improve supports for college students with TBI.

- The student’s CST case manager and/or guidance counselor provide preliminary college advice before the student graduates from high school, but it is up to the student with TBI to disclose pertinent medical and educational assessment information and to advocate for him/herself in order to obtain necessary accommodations and support services to successfully navigate the college experience. It is essential that staff assigned to the disabilities support offices are knowledgeable regarding TBI consequences and its impact at the college level in order to assist students, to serve as liaison to the faculty, and to ensure compliance with Section 504 of the Rehabilitation Act of 1973, as amended (Section 504) and the Amendments Act of 2008, which amended the Americans with Disabilities Act of 1990 (ADA). Colleges should assess the training needs of their staff regarding TBI and should utilize online courses and the resources of organizations such as BIANJ, if necessary.
Recommendation #7: Increase Awareness of TBI

- Develop a TBI (including concussion) awareness campaign for educators and students (similar to the “anti-bullying” efforts in schools) and for professionals and the public to increase awareness of TBI prevention, identification, and treatment.

  - In addition to providing training and information to school staff, outreach efforts (flyers, public service announcements, safe driving campaigns, etc.) should focus on students of all ages, not just on concussion awareness for those involved in sports. This should also be aimed at professionals and the public. As the mechanism of injury for TBI varies (e.g., falls, assaults, sports injuries, etc.) and the point of entry following the injury varies (e.g., trauma center, emergency room, urgent care clinic, pediatrician, primary care physician, child protection services, concussion healthcare specialist, etc.), it is also important to outreach to various healthcare and health/human service agencies to raise awareness of the importance of the identification of TBI and connection to support/resources, particularly in instances where the consequences of the injury may not manifest immediately, but rather evolve over time.

  - In a recent survey by BIANJ, in response to the question ‘Who diagnosed your child’s brain injury?’, parents reported a variety of professionals, including neurologists, emergency room physicians, neuropsychologists, pediatricians, primary care physicians, developmental pediatricians, concussion specialists, and physiatrists. Therefore, any outreach approach would need to be multi-pronged, in particular because proper identification of TBI will facilitate access to services for both the child and the family. An article in 2008 about researchers studying brain injury (much of it conducted at the Brain Injury Research Center at Mount Sinai School of Medicine in New York) stated that a common thread running through many cases of apparently unrelated social problems is a long-forgotten blow to the head. Among their findings, it was noted that therapy provided to those with an underlying brain injury often helped individuals with a variety of ills ranging from learning disabilities to chronic homelessness and alcoholism.

- Provide parents with information on what they can expect the schools to do for a child with TBI, both what is reasonable and what is unreasonable to expect.

  - As previously noted, informational packets should be provided to parents when their child is registered with the TBI registry and/or by the Regional TBI Education Consultants, BIRT teams, or other school personnel. One such resource that is available on BIANJ’s website is a booklet entitled ‘Brain Injury: A Guide for Families.’
Expand outreach to state agency personnel, medical professionals, and the public to ensure that children with TBI are being referred to Project CHILD FIND

- Project CHILD FIND is a free statewide referral service and public awareness campaign to assist in the identification of unserved/underserved children from birth through twenty-one years of age who may have a developmental delay or disability due to physical, sensory, emotional, communication, cognitive, or social difficulties. In addition, Project CHILD FIND develops and distributes information to the public about New Jersey’s early intervention services and special education programs. It is recommended that outreach and support to Project CHILD FIND staff take place to educate and raise awareness of TBI, including signs, symptoms, and the various mechanisms of injury. As TBI is often referred to as the “silent epidemic,” those affected by TBI, as well as those professionals making the TBI diagnosis, may be underutilizing Project CHILD FIND as a resource for parents and children.

Recommendation #8: Investigate Funding Possibilities, Legislative Actions, and Interagency Collaboration

- Explore grant possibilities for training/professional development for the TBI Education Consultants and school staff
  - The DOE should explore grant possibilities (e.g., IDEA Part B discretionary funds, Memorandum of Understanding/contract between the DOE and BIANJ, Memorandum of Agreement between the DOE and DHS/TBI Trust Fund to supplement grant funding for BIANJ to expand their activities, grants from the Health Resources and Services Administration, etc.). There should be coordination with BIANJ and DHS for a DOE-sponsored workshop or webinar on best practices in evaluation, provision of programs/services, and accommodations/modifications for students with TBI.

- Mandate the positions of TBI Education Coordinator and four Regional TBI Educational Consultants
  - To ensure the establishment and continuation of a TBI Education Coordinator within the DOE and four Regional TBI Education Consultants, the Task Force recommends that legislation be enacted to mandate these positions.

- Establish an Executive Oversight Board by Executive Order
  - To ensure that the Task Force’s proposed recommendations are acted upon, there must be oversight and follow-up. The purpose of the Executive Oversight Board (EOB) would be to ensure the development of an implementation plan that puts into operation the recommendations contained in the Task Force report, and maintains the Administration’s focus on the needs of students with TBI. The Task Force recommends the EOB be convened by the Governor and include key cabinet level representatives, including, among others, the Commissioners of Human Services,
Establish the New Jersey Special Education and TBI Task Force as an ongoing Advisory Council

- To ensure that the work done by the Task Force over the past year continues, it is recommended that an advisory council be established through the Governor’s Office, Appointments Department. The recommendations of the Task Force necessitate collaboration among various professionals and organizations, and an ongoing New Jersey Special Education TBI Advisory Council could facilitate further collaboration.

Establish a Statewide Disabilities Board

- The Task Force recognizes a lack of collaboration and communication among various state offices, and also recognizes that a number of Advisory Councils currently exist in order to bridge that gap. However, the gap remains and, as a result, opportunities for collaboration that could potentially assist students with TBI as well as other individuals with disabilities are lost. The Task Force recommends investigating ways to improve communication and collaboration across agencies through the establishment of a statewide disabilities board. The objective of the board would also be to establish guidelines and identify common practices and procedures that would bring about better outcomes and increase cost efficiencies, thereby creating a “Best Practices Model.”

- It is recommended that the statewide disabilities board include representation, at the Commissioner level, from all state government departments with divisions/agencies that have a connection to individuals with disabilities, including, but not limited to the Departments of Human Services, Education, Health, Children and Families, Labor and Workforce Development, Banking and Insurance, Community Affairs, and Corrections. Other members should include medical experts, family members, and the service providers community (e.g., neuropsychologist, social worker, school nurse, rehabilitation experts, etc.).

- The board would meet on a regular basis to develop a cross division model for all people with disabilities in order to determine:
  - How to share information across divisions to improve outcomes and reduce costs;
  - How to develop a registry for all disabilities to properly identify all students;
  - How to coordinate transportation and services for all disabilities;
  - How to use economies of scale to improve services and reduce costs;
  - How to coordinate case management;
  - How to identify statewide resources to address educational, social, medical, and community needs of students with TBI; and
  - How to ensure enforcement of current TBI-related legislation.
Bring the insurance companies to the table to help support advocacy and education programs in order to lower costs associated with therapy needs and cognitive rehabilitation of students with TBI and to review current TBI-related benefits.

- There are a variety of assessments and therapies often recommended by healthcare professionals following an identified TBI, including a neuropsychological evaluation, physical therapy, occupational therapy, speech therapy and/or cognitive therapy. As students transition back to school, there may be a continued need for these therapies and assessments, which may or may not be covered by the student’s medical insurance (public or private health insurance, auto insurance, etc.). An insurance company’s refusal to cover recommended therapies may result in the parents bearing the brunt of the cost when those services are not determined to be needed by a student’s IEP or 504 team. As such, the Task Force recommends bringing the insurance companies to the table, along with the New Jersey Department of Banking and Insurance, to discuss the needs of students with brain injury and how the limits of insurance often impact both the families of students with TBI and the educational system.

Recommendation #9: Revise New Jersey Administrative Code (N.J.A.C.), Title 6A, Chapters 14 and 9

- Amend Special Education, Chapter 14 to broaden the TBI definition

As previously noted, since 1998, New Jersey’s special education regulations have included TBI as a category of eligibility for special education and related services, consistent with IDEA’s federal definition of TBI. The Task Force recommends that the existing definition at N.J.A.C. 6A:14-3.5(c)13 be amended to adopt the broader definition that Ohio and a few other states currently utilize. Ohio’s educational definition of TBI is not restricted to injuries resulting from external trauma. It is more inclusive than the IDEA definition, covering conditions such as strokes, tumors, and injuries caused by surgical treatments. Expansion of the federal definition would allow more children with brain injuries to be identified under the TBI category for the purpose of receiving special education and related services. Thus, the following revisions are recommended for the TBI definition at N.J.A.C. 6A:14-3.5(c)13:

"Traumatic brain injury" corresponds to "neurologically impaired" and means an acquired injury to the brain caused by an external physical force or [insult to the brain] **by other medical conditions, including but not limited to stroke, anoxia, infectious disease, aneurysm, brain tumors, and neurological insults resulting from medical or surgical treatments**, resulting in total or partial functional disability or psychosocial impairment, or both. The term applies to open or closed head injuries **as well as to other medical conditions that result in acquired brain injuries**, resulting in impairments in one or more areas, such as cognition; language; memory; attention; reasoning; abstract thinking; judgment; problem-solving; sensory,
perceptual and motor abilities; psychosocial behavior; physical functions; information processing; and speech. The term does not apply to brain injuries that are congenital or degenerative, or to brain injuries induced by birth trauma.

❖ Amend Professional Licensure and Standards, Chapter 9 to include TBI in the professional standards for teachers

- In order to improve educator awareness of TBI, teachers should be required to know and understand the needs of students with TBI and the possible educational implications. Thus, the following revision is recommended for standard seven at N.J.A.C. 6A:9-3.3(a)7:

7. Standard Seven: Special Needs. Teachers shall adapt and modify instruction to accommodate the special learning needs of all students.
   i. Teachers know and understand:
      (1) How to access information regarding applicable laws, rules, regulations and procedural safeguards regarding planning and implementing the individual education program;
      (2) Available resources related to educational strategies for instruction and methods of teaching to accommodate individual differences and to employ positive behavioral intervention techniques for students with special needs including students with autism and other developmental disabilities; and
      (3) The characteristics of students with special needs, including students with traumatic brain injuries.

Recommendation #10: Improve Services for Individuals with TBI in Psychiatric Institutions and the Juvenile Justice System and Reduce Future Incarceration

❖ Increase awareness of TBI (including concussion) for educators and personnel who work in psychiatric institutions and the juvenile justice system

- This would help to ensure appropriate evaluations and therapeutic/educational services when a TBI is suspected or documented for individuals at such facilities, whether or not they have IEPs.

❖ Establish a TBI identification (screening) program for children and young adults in psychiatric institutions and the juvenile justice system

- TBI can contribute to future legal difficulties and psychiatric issues due to the acquired cognitive and behavioral areas of weakness. Therefore, identification and intervention in a pediatric brain injury population could assist in preventing or lessening later criminal involvement. By providing better and appropriate support, earlier in life, there is potential to reduce the offender population. To be effective, this should start to take place within the education environment and with the full support of educators.
- The CDC estimates that 2% of the US population is living with brain injury. However, the incidence for criminal offenders is much higher. Meta-analysis of medical journals from 1983 to 2010 estimated that 60.25% to 83% of the overall offender population had a previous TBI. In a 2003 study of youth offenders in Missouri, 18.3% reported a lifetime TBI with loss of consciousness more than 20 minutes. These TBI youths compared with non-TBI were more likely to have a prior psychiatric diagnosis, earlier onset of criminal behavior and substance abuse, a criminal act in the past year, lifetime suicidality, impulsivity, increased fearless behavior, and were also more likely to have been victimized within the last year.

- A 2005 study of 117 children, ages 5-14 with TBI, admitted to trauma centers were followed at baseline and 6 months post TBI. Personality changes occurred in 22% of the patients, with severity of the injury predicting personality changes. Disturbances commonly seen after TBI, as noted in medical literature, included disinhibition, apathy, inattention, behavioral immaturity, irritability, increased anger and aggression, impulsivity, social awkwardness, withdrawal, hyperactivity, anxiety, and depression. Preschoolers with TBI were more likely to have a behavioral diagnosis later in life than those who sustained TBI in later school years.
References - Print and Online


New Jersey Department of Education, Special Education Data. 2012


Slaugther, B. Fann, J. & Ehde, D. *Traumatic brain injury in a county jail population; prevalence, neuropsychological functioning, and psychiatric disorders.* Brain Injury. 2003; 17(9).
References - Internet Resources

Brain Injury Alliance of New Jersey (BIANJ)
http://bianj.org/

Brain Injury School Re-Entry Program (BrainSTEPS) – Pennsylvania’s TBI Website
http://www.brainsteps.net/

Center on Brain Injury Research and Training (CBIRT) – Oregon’s TBI Website
http://cbirt.org/

Centers for Disease Control and Prevention (CDC)
http://www.cdc.gov/TraumaticBrainInjury/

Colorado Kids with Brain Injury – Colorado’s TBI Website
http://cokidswithbraininjury.com/

New Jersey Commission on Brain Injury Research
http://www.state.nj.us/health/njcbir/index.shtml

New Jersey Department of Education
http://www.state.nj.us/education/

New Jersey Department of Education, Concussion Information
http://www.state.nj.us/education/aps/cccs/chpe/concussions/

New Jersey Department of Health
http://www.state.nj.us/health/

New Jersey Department of Human Services
http://www.state.nj.us/humanservices/

New Jersey Department of Human Services, Division of Disability Services, TBI Fund
http://www.state.nj.us/humanservices/dds/oias/tbis/tbifund.html

Oregon Concussion Awareness and Management Program
http://www.ocamp.org/
References - Website Links to New Jersey Legislation Regarding TBI

**Brain Injury Research Act** - Public Law 2003, Chapter 200 – established the New Jersey State Commission on Brain Injury Research in the executive Branch of the State government to review and authorize brain injury research projects and to establish and maintain, in conjunction with the DOH, a central registry of persons who sustain brain injuries other than through disease, whether or not the injury results in a permanent disability, in order to provide a database that indicates the incidence and prevalence of brain injuries and that will serve as a resource for research, evaluation and information on brain injuries and available services.  
http://www.njleg.state.nj.us/2002/Bills/PL03/200_.HTM

http://www.njleg.state.nj.us/2010/Bills/PL10/94_.HTM

**New Jersey Advisory Council on TBI and the TBI Trust Fund** - Public Law 2001, Chapter 332 — established the New Jersey Advisory Council on TBI, in the DHS, to advise and make recommendations to DHS and other related State agencies on ways to improve and develop services regarding TBI, including the coordination of these services between public and private entities and to advise the Commissioner, DHS on the administration of the TBI Fund established pursuant to this act.  The TBI fund distributes monies as the payer of last resort, for costs of post-acute care, services and financial assistance to residents who have survived a TBI and funds public information and prevention education activities coordinated by BIANJ.  
ftp://www.njleg.state.nj.us/20002001/PL01/332_.HTM

**New Jersey Special Education and TBI Task Force** - Public Law 2009, Chapter 250 – established the New Jersey Special Education and TBI Task Force to study instructional practices and strategies that improve recognition of, and benefit students with, a TBI and examine the ways in which current State policies affect this population.  
http://www.njleg.state.nj.us/2008/Bills/PL09/250_.PDF
Glossary

**Child Study Team (CST)** - professionals who provide consultative, evaluative, and prescriptive services to teachers and parents in regard to students who are experiencing school related difficulties. As mandated by New Jersey’s special education regulations, CST members include a school psychologist, a learning disabilities teacher-consultant, and a school social worker. At times, the speech-language specialist may act as a member of the CST. These team members also serve as case managers for students receiving special education and related services and work closely with both special education and general education teachers to develop students' Individualized Education Programs (IEPs).

**Executive Functions (EF)** - refers to those skills that are critical in goal setting, planning, organizing, self-directing, self-monitoring, evaluating one’s plan or strategy and changing it if necessary, problem solving, and prioritizing. These skills are associated with the prefrontal area of the brain and are highly vulnerable to brain injuries. Examples of EF impact on learning include: writing, note-taking, summarizing, reading comprehension, and math word problems.

**Glasgow Coma Scale (GCS)** - a neurological scale that aims to give a reliable, objective way of recording the conscious state of a person for initial as well as subsequent assessment. A patient is assessed against the criteria of the scale, and the resulting points give a patient score between 3 (indicating deep unconsciousness) and either 14 (original scale) or 15 (the more widely used modified or revised scale).

**Individuals with Disabilities Education Act**, as amended by the Individuals with Disabilities Education Improvement Act of 2004 (IDEA) - the federal law that requires the provision of special education and related services to students classified as having a disability through a multidisciplinary assessment and IEP process. (See IDEA website at: [http://idea.ed.gov/](http://idea.ed.gov/)).

**Individualized Education Program (IEP)** - a written plan which sets forth present levels of academic achievement and functional performance, measurable annual goals and short-term objectives or benchmarks and describes an integrated, sequential program of individually designed instructional activities and related services necessary to achieve the stated goals and objectives. The IEP establishes the rationale for the student’s educational placement, serves as the basis for program implementation and must comply with state and federal mandates.

**Individualized Emergency Healthcare Plan (IEHP)** - a personalized healthcare plan written by the certified school nurse that specifies the delivery of accommodations and services needed by a student in the event of an emergency.

**Individualized Healthcare Plan (IHP)** - a plan written by the certified school nurse that details accommodations and/or nursing services to be provided to a student because of the student’s medical condition, based on medical orders written by a physician in the student’s medical home.
**Intervention and Referral Services (I & RS)** - a school building’s coordinated services and multidisciplinary team delivery system designed to address the full range of student learning, behavior, and health problems in the general education program, as well as to assist students who have been determined to be in need of special education programs and related services, in coordination with the student’s IEP team, as appropriate.

**Related Services** - services that include, but are not limited to, counseling, occupational therapy, physical therapy, school nurse services, recreation, social work services, medical services, and speech-language services that shall be provided to a student with a disability when required for the student to benefit from the educational program.

**Section 504 of the Rehabilitation Act of 1973, as amended (Section 504)** - a civil rights statute that protects qualified individuals from discrimination based on their disability. The nondiscrimination requirements of the law apply to employers and organizations that receive financial assistance from any Federal department or agency. The Amendments Act of 2008, which amended the Americans with Disabilities Act of 1990 (ADA) broadens the interpretation of disability. Students determined eligible under 504 will have a 504 accommodation plan. (See FAQ at: [http://www2.ed.gov/about/offices/list/ocr/504faq.html](http://www2.ed.gov/about/offices/list/ocr/504faq.html)).

**Temporary Accommodations** - short duration academic adjustments tailored to a student’s specific circumstances following concussion/MTBI. These short-term strategies are designed to help prevent permanent damage to a student's academic record during the recovery process.
Appendix A

NEW JERSEY SPECIAL EDUCATION AND TBI TASK FORCE - P.L.2009, c.250
CHAPTER 250

AN ACT establishing the New Jersey Special Education and Traumatic Brain Injury Task Force.

BE IT ENACTED by the Senate and General Assembly of the State of New Jersey:

1. The Legislature finds and declares that:
   a. A traumatic brain injury is an acquired injury to the brain caused by an external physical force or insult to the brain, resulting in total or partial functional disability or psychosocial impairment, or both;
   b. According to the New Jersey Department of Health and Senior Service’s Center for Health Statistics, in 2007 approximately 1,231 children in New Jersey under the age of 18 were hospitalized with moderate to severe traumatic brain injury, and an additional 22,436 children under 18 were seen in hospital emergency departments with mild traumatic brain injury which may result in reduced concentration, attention, and other performance problems;
   c. In 1998, the category of traumatic brain injury was added to the list of disabilities included in State Board of Education regulations for which a student may be eligible for special education and related services, and currently 1,260 students are receiving special education services under this classification;
   d. A marked discrepancy exists between the number of students receiving special education services under the classification of traumatic brain injury and the number of children who sustain a brain injury each year;
   e. At the time that the State Board of Education adopted the classification category of traumatic brain injury, at least 36 states offered in-service professional development on traumatic brain injury to accompany the introduction of this special education classification. However, no formal training has ever been offered to assist New Jersey educators on how to recognize, classify, and educate students with a traumatic brain injury, resulting in inappropriate classification for many students suffering from such injury and a lack of educational programs for students who are appropriately classified; and
   f. It is therefore in the public interest of the students in this State to establish a New Jersey Special Education and Traumatic Brain Injury Task Force to study instructional practices and strategies that improve recognition of, and benefit students with, a traumatic brain injury and examine the ways in which current State policies affect this population.

2. a. There is hereby established the New Jersey Special Education and Traumatic Brain Injury Task Force. The purpose of the task force shall be to: develop best practices and processes for education professionals working with students with a traumatic brain injury; address the needs of students with a traumatic brain injury; study and evaluate practices for recognizing and educating children with traumatic brain injuries of all types, ranging from mild to severe; prepare students with a traumatic brain injury for entry into college or the work force; and examine how current statutes and regulations affect these students in order to develop recommendations to be presented to the Governor and the Legislature. The task
force shall also focus upon recognition by all educational professionals of the signs and symptoms of mild traumatic brain injury in order to promote cognitive rest until the student recovers and to help avoid re-injury. The task force shall examine the correlation between traumatic brain injury and psychiatric illness and potential future incarceration.

b. The task force shall consist of 18 members as follows:
   (1) the Commissioners of Education and Human Services, or their designees, who shall serve ex officio; and
   (2) 16 members who shall be appointed no later than the 30th day after the effective date of this act, as follows:
      (a) 14 persons appointed by the Governor, who shall include: one representative of the Department of Education, one representative of the Department of Human Services, one representative of the Department of Health and Senior Services, two representatives of the Brain Injury Association of New Jersey, two parents of children who have suffered a traumatic brain injury, two pediatric rehabilitation professionals with knowledge of traumatic brain injury, one school social worker, one school nurse, one special education teacher, one director of special education services for a school district, and one representative of the Athletic Trainers’ Society of New Jersey; and
      (b) two members of the public, one selected by the President of the Senate and one selected by the Speaker of the General Assembly, with demonstrated expertise in issues relating to the work of the task force.

Vacancies in the membership of the task force shall be filled in the same manner as the original appointments were made.

c. The Commissioner of Education, or the commissioner’s designee, shall serve as chairperson of the task force. The task force shall organize as soon as practicable following the appointment of its members and shall select a vice-chairperson from among its members. The chairperson shall appoint a secretary who need not be a member of the task force.

d. The public members shall serve without compensation, but shall be reimbursed for necessary expenses incurred in the performance of their duties and within the limits of funds available to the task force.

e. The Department of Education shall provide such stenographic, clerical and other administrative assistants, and such professional staff, as the task force requires to carry out its work. The task force shall also be entitled to call to its assistance and avail itself of the services of the employees of any State, county, or municipal department, board, bureau, commission, or agency as it may require and as may be available to it for its purposes.

3. The task force shall report its findings and recommendations to the Governor, and to the Legislature pursuant to section 2 of P.L.1991, c.164 (C.52:14-19.1), along with any legislative bills that it desires to recommend for adoption by the Legislature, no later than 12 months after the initial meeting of the task force.

4. This act shall take effect immediately and shall expire upon the issuance of the task force report.

## Appendix B

### STATE OF NEW JERSEY

#### HEALTH HISTORY AND APPRAISAL

**IMMUNIZATION REGISTRY NUMBER**

**Name of Child (Last, First, M.I.)**

Date of Birth (Mo/Day/Yr)  Sex: [ ] Male  [ ] Female

**PARENT OR GUARDIAN**

**NAME**

**ADDRESS**

**TELEPHONE NO.**

### VACCINE TYPE

<table>
<thead>
<tr>
<th>VACCINE TYPE</th>
<th>1st Dose Mo/Day/Yr</th>
<th>2nd Dose Mo/Day/Yr</th>
<th>3rd Dose Mo/Day/Yr</th>
<th>4th Dose Mo/Day/Yr</th>
<th>5th Dose Mo/Day/Yr</th>
<th>LEAD SCREENING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diphtheria, Tetanus, Pertussis (DTaP) or any combination (If Td or DT, indicate in corner box)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Td</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Polio, Inactivated Polio Vaccine (IPV)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If oral vaccine, indicate (OPV) in corner box</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles, Mumps, Rubella (MMR)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haemophilus B (Hib)**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hepatitis B</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Measles</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mumps</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rubella</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Document below single antigen vaccine receipt, serology titers, or varicella disease history**

### OTHER

[ ] Provisional admission attached

[ ] Date Granted

[ ] Medical exemption attached

[ ] Religious exemption attached

### HISTORY

<table>
<thead>
<tr>
<th>YEAR</th>
<th>HISTORY</th>
<th>YEAR</th>
<th>HISTORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>FOOD ALLERGIES</td>
<td>DIABETES</td>
<td>LYME DISEASE</td>
<td>JUVENILE RHEUMATOID ARTHRITIS</td>
</tr>
<tr>
<td>NON-FOOD NON-MEDICINE ALLERGIES</td>
<td>INFLUENZA (FLU)</td>
<td>MONONUCLEOSIS</td>
<td>AUTISM SPECTRUM DISORDERS</td>
</tr>
<tr>
<td>DRUG ALLERGIES</td>
<td>NEUROMUSCULAR DISORDER</td>
<td>NEUROMUSCULAR DISORDERS</td>
<td></td>
</tr>
<tr>
<td>ASTHMA</td>
<td>CHRONIC CONVULSIVE DISORDER</td>
<td>HEART DISEASE</td>
<td>AUTO IMMUNE DISORDERS</td>
</tr>
<tr>
<td>CONGENITAL DISORDER</td>
<td>CHRONIC OTITIS MEDIA</td>
<td>ADD/ADHD</td>
<td></td>
</tr>
<tr>
<td>CONVULSIVE DISORDER</td>
<td>STREP INFECTIONS</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### HEALTH SCREENING CODE: N = Normal; R = Referred; T = Under Treatment; C = See Comments

**Grade/Age**

| Date | | | |
|------| | | |

**Height**

<table>
<thead>
<tr>
<th>Weight</th>
</tr>
</thead>
</table>

**BMI**

**Blood Pressure**

**VISION**

<table>
<thead>
<tr>
<th>With correction</th>
<th>L</th>
<th>R</th>
</tr>
</thead>
<tbody>
<tr>
<td>BOTH</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Without correction</td>
<td>L</td>
<td>R</td>
</tr>
<tr>
<td>BOTH</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Muscle Balance**

<table>
<thead>
<tr>
<th>Color Perception</th>
<th>Date</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sweep Check</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### BIENNIAL SCOLIOSIS SCREENING

**Beginning at Age 13**

| Date | Date | Date |

**Referred for abnormal result**

**TB Screening ( Mantoux Test)**

<table>
<thead>
<tr>
<th>Tested</th>
<th>Read</th>
<th>Result (MM)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Medication**

**Reactor No Rx**

**Date Started**

**Date Completed**

*REQUIRED FOR DAY/CHILD CARE ENROLLERS (2 Months-8th Birthday Only)***

**Not Required**

**A-43** STATE OF NEW JERSEY DEPARTMENT OF EDUCATION/DEPARTMENT OF HEALTH

**Revised June 2012**

36
Appendix C

NEW JERSEY BRAIN INJURY RESEARCH ACT - P.L.2003, c.200
CHAPTER 200

AN ACT establishing a New Jersey Commission on Brain Injury Research, supplementing Title 52 of the Revised Statutes and amending R.S.39:5-41.

BE IT ENACTED by the Senate and General Assembly of the State of New Jersey:

C.52:9EE-1 Short title.
1. This act shall be known and may be cited as the "Brain Injury Research Act."

C.52:9EE-2 Definitions relative to brain injury research.
2. As used in this act:
   "Approved research project" means a scientific research project, which is approved by the commission and which focuses on the treatment and cure of brain injuries.
   "Commission" means the New Jersey State Commission on Brain Injury Research established pursuant to this act.
   "Institutional support services" means all services, facilities, equipment, personnel and expenditures associated with the creation and maintenance of approved research projects.
   "Qualifying research institution" means the University of Medicine and Dentistry of New Jersey and Rutgers, The State University of New Jersey and any other institution approved by the commission, which is conducting an approved research project.

C.52:9EE-3 New Jersey State Commission on Brain Injury Research.
3. a. There is established in the Executive Branch of the State government, the New Jersey State Commission on Brain Injury Research. For the purposes of complying with the provisions of Article V, Section IV, paragraph 1 of the New Jersey Constitution, the commission is allocated within the Department of Health and Senior Services, but notwithstanding that allocation, the commission shall be independent of any supervision or control by the department or by any board or officer thereof.
   b. The commission shall consist of 11 members, including the Commissioner of Health and Senior Services, or his designee, who shall serve ex officio; one representative of the University of Medicine and Dentistry of New Jersey; one representative of Rutgers, The State University of New Jersey; six public members, appointed by the Governor with the advice and consent of the Senate, one of whom shall be a licensed physician in this State and one of whom shall be a person with a brain injury; and two public members, one of whom shall be appointed by the President of the Senate and one of whom shall be appointed by the Speaker of the General Assembly. All public members shall be residents of the State or otherwise associated with the State, and shall be known for their knowledge, competence, experience or interest in brain injury medical research.
   c. The term of office of each public member shall be three years, but of the members first appointed, three shall be appointed for terms of one year, three for terms of two years, and two for terms of three years. All vacancies shall be filled for the balances of the unexpired terms in the same manner as the original appointments. Appointed members are eligible for...
reappointment upon the expiration of their terms. A member shall continue to serve upon the expiration of his term until a successor is appointed.

The members of the commission shall not receive compensation for their services, but shall be reimbursed for the actual and necessary expenses incurred in the performance of their duties as members of the commission.

C.52:9EE-4 Duties of commission.
4. The commission shall:
   a. Review and authorize approved research projects, emphasizing projects that study nerve regeneration as a means to a cure for brain injury, and may establish an independent scientific advisory panel composed of scientists and clinicians who are not members of the commission to review proposals submitted to the commission and make funding recommendations to the commission;
   b. Apportion all available funds to qualifying research institutions to finance approved research projects and necessary institutional support services;
   c. Ensure that funds so apportioned to approved research projects are not diverted to any other use;
   d. Take steps necessary to encourage the development within the State of brain injury research projects;
   e. Compile a directory of all brain injury research projects being conducted in the State; and
   f. Provide the Governor and the Legislature with a report by January 30 of each year describing the status of the commission's activities and the results of its funded research efforts.

C.52:9EE-5 Authority of commission.
5. The commission is authorized to:
   a. Adopt rules and regulations concerning the operation of the commission, the functions and responsibilities of its officers and employees, the use of moneys from the "New Jersey Brain Injury Research Fund" established pursuant to section 9 of P.L.2003, c.200 (C.52:9EE-9) to meet the operating expenses of the commission, and other matters as may be necessary to carry out the purposes of this act;
   b. Maintain offices at such places within the State as it may designate;
   c. Employ an executive director and other personnel as may be necessary, whose employment shall be in the unclassified service of the State, except that employees performing stenographic or clerical duties shall be appointed pursuant to Title 11A (Civil Service) of the New Jersey Statutes;
   d. Design a fair and equitable system for the solicitation, evaluation and approval of proposals for brain injury research projects;
   e. Apply for and accept any grant of money from the federal government, which may be available for programs relating to research on brain injury;
   f. Enter into contracts with individuals, organizations and institutions necessary or incidental to the performance of its duties and the execution of its powers under this act; and
   g. Accept gifts, grants and bequests of funds from individuals, foundations, corporations, governmental agencies and other organizations and institutions.
C.52:9EE-6 Election of officers.
   6. The commission shall annually elect a chairman and a vice-chairman from among its members. The chairman shall be the chief executive officer of the commission, shall preside at all meetings of the commission and shall perform other duties that the commission may prescribe.
   The executive director shall serve as secretary to the commission and shall carry out its policies under the direction of the chairman.

C.52:9EE-7 Direct applications for funds.
   7. Nothing in this act shall preclude a qualifying research institution or any other research facility in the State from directly applying for or receiving funds from any public or private agency to conduct brain injury research.

C.52:9EE-8 Central registry of persons who sustain brain injuries.
   8. a. The commission shall establish and maintain, in conjunction with the Department of Health and Senior Services, a central registry of persons who sustain brain injuries other than through disease, whether or not the injury results in a permanent disability, in order to provide a database that indicates the incidence and prevalence of brain injuries and that will serve as a resource for research, evaluation and information on brain injuries and available services.
   b. The commission shall require the reporting of all cases of brain injuries, except those caused through disease, and the submission of specified additional information on reported cases as it deems necessary and appropriate.
   The commission shall, by regulation, specify the health care facilities and providers required to make the report of a brain injury to the registry, information that shall be included in the report to the registry, the method for making the report and the time period in which the report shall be made.
   c. The reports made pursuant to this section are to be used only by the commission and the Department of Health and Senior Services and such other agencies as may be designated by the commission or the department and shall not otherwise be divulged or made public so as to disclose the identity of any person to whom they relate; and to that end, the reports shall not be included under materials available to public inspection pursuant to P.L.1963, c.73 (C.47:1A-1 et seq.) and P.L.2001, c.404 (C.47:1A-5 et al.).
   d. No individual or organization providing information to the commission in accordance with this section shall be deemed to be, or held liable for, divulging confidential information. Nothing in this section shall be construed to compel any individual to submit to medical, commission or department examination or supervision.
   e. A health care facility or health care provider who is required to report a brain injury to the commission and who fails to comply with the provisions of this section shall be liable to a penalty of up to $100 per unreported brain injury case. A penalty sued for under the provisions of this section shall be recovered by and in the name of the commission and shall be deposited in the "New Jersey Brain Injury Research Fund" established pursuant to this act.

C.52:9EE-9 "New Jersey Brain Injury Research Fund."
   9. a. There is established in the Department of the Treasury a nonlapsing revolving fund to be known as the "New Jersey Brain Injury Research Fund." This fund shall be the repository for moneys provided pursuant to subsection f. of R.S.39:5-41. Moneys deposited in the fund, and
any interest earned thereon, shall be used for the purpose of making grants for brain injury research projects at qualified research institutions approved by the New Jersey State Commission on Brain Injury Research, and for the purpose of meeting the operating expenses of the commission.

b. Any costs incurred by the department in the collection or administration of the fund may be deducted from the funds deposited therein, as determined by the Director of the Division of Budget and Accounting.

10. R.S.39:5-41 is amended to read as follows:

Fines, penalties, forfeitures, disposition of; exceptions.

39:5-41. a. All fines, penalties and forfeitures imposed and collected under authority of law for any violations of R.S.39:4-63 and R.S.39:4-64 shall be forwarded by the judge to whom the same have been paid to the proper financial officer of a county, if the violation occurred within the jurisdiction of that county's central municipal court, established pursuant to N.J.S.2B:12-1 et seq. or the municipality wherein the violation occurred, to be used by the county or municipality to help finance litter control activities in addition to or supplementing existing litter pickup and removal activities in the municipality.

b. Except as otherwise provided by subsection a. of this section, all fines, penalties and forfeitures imposed and collected under authority of law for any violations of the provisions of this Title, other than those violations in which the complaining witness is the director, a member of his staff, a member of the State Police, a member of a county police department and force or a county park police system in a county that has established a central municipal court, an inspector of the Board of Public Utilities, or a law enforcement officer of any other State agency, shall be forwarded by the judge to whom the same have been paid as follows: one-half of the total amount collected to the financial officer, as designated by the local governing body, of the respective municipalities wherein the violations occurred, to be used by the municipality for general municipal use and to defray the cost of operating the municipal court; and one-half of the total amount collected to the proper financial officer of the county wherein they were collected, to be used by the county as a fund for the construction, reconstruction, maintenance and repair of roads and bridges, snow removal, the acquisition and purchase of rights-of-way, and the purchase, replacement and repair of equipment for use on said roads and bridges therein. Up to 25% of the money received by a municipality pursuant to this subsection, but not more than the actual amount budgeted for the municipal court, whichever is less, may be used to upgrade case processing.

All fines, penalties and forfeitures imposed and collected under authority of law for any violations of the provisions of this Title, in which the complaining witness is a member of a county police department and force or a county park police system in a county that has established a central municipal court, shall be forwarded by the judge to whom the same have been paid to the financial officer, designated by the governing body of the county, for all violations occurring within the jurisdiction of that court, to be used for general county use and to defray the cost of operating the central municipal court.

Whenever any county has deposited moneys collected pursuant to this section in a special trust fund in lieu of expending the same for the purposes authorized by this section, it may withdraw from said special trust fund in any year an amount which is not in excess of the amount expended by the county over the immediately preceding three-year period from general county revenues.
for said purposes. Such moneys withdrawn from the trust fund shall be accounted for and used as are other general county revenues.

c. (Deleted by amendment, P.L.1993, c.293.)

d. Notwithstanding the provisions of subsections a. and b. of this section, $1 shall be added to the amount of each fine and penalty imposed and collected through a court under authority of any law for any violation of the provisions of Title 39 of the Revised Statutes or any other motor vehicle or traffic violation in this State and shall be forwarded by the person to whom the same are paid to the State Treasurer. In addition, upon the forfeiture of bail, $1 of that forfeiture shall be forwarded to the State Treasurer. The State Treasurer shall annually deposit those moneys so forwarded in the "Body Armor Replacement" fund established pursuant to section 1 of P.L.1997, c.177 (C.52:17B-4.4). Beginning in the fiscal year next following the effective date of this act, the State Treasurer annually shall allocate from those moneys so forwarded an amount not to exceed $400,000 to the Department of Personnel to be expended exclusively for the purposes of funding the operation of the "Law Enforcement Officer Crisis Intervention Services" telephone hotline established and maintained under the provisions of P.L.1998, c.149 (C.11A:2-25 et al.).

e. Notwithstanding the provisions of subsections a. and b. of this section, $1 shall be added to the amount of each fine and penalty imposed and collected through a court under authority of any law for any violation of the provisions of Title 39 of the Revised Statutes or any other motor vehicle or traffic violation in this State and shall be forwarded by the person to whom the same are paid to the State Treasurer. The State Treasurer shall annually deposit those moneys so forwarded in the "New Jersey Spinal Cord Research Fund" established pursuant to section 9 of P.L.1999, c.201 (C.52:9E-9). In order to comply with the provisions of Article VIII, Section II, paragraph 5 of the State Constitution, a municipal or county agency which forwards moneys to the State Treasurer pursuant to this subsection may retain an amount equal to 2% of the moneys which it collects pursuant to this subsection as compensation for its administrative costs associated with implementing the provisions of this subsection.

f. Notwithstanding the provisions of subsections a. and b. of this section, during the period beginning on the effective date of this act and ending five years thereafter, $1 shall be added to the amount of each fine and penalty imposed and collected through a court under authority of any law for any violation of the provisions of Title 39 of the Revised Statutes or any other motor vehicle or traffic violation in this State and shall be forwarded by the person to whom the same are paid to the State Treasurer. The State Treasurer shall annually deposit those moneys so forwarded in the "Autism Medical Research and Treatment Fund" established pursuant to section 1 of P.L.2003, c.144 (C.30:6D-62.2).

g. Notwithstanding the provisions of subsection a. and b. of this section, $2 shall be added to the amount of each fine and penalty imposed and collected by a court under authority of any law for any violation of the provisions of Title 39 of the Revised Statutes or any other motor vehicle or traffic violation in this State and shall be forwarded by the person to whom the same are paid to the State Treasurer. The State Treasurer shall annually deposit those moneys so forwarded in the "New Jersey Forensic DNA Laboratory Fund" established pursuant to P.L.2003, c.183. Prior to depositing the moneys into the fund, the State Treasurer shall forward to the Administrative Office of the Courts an amount not to exceed $475,000 from moneys initially collected pursuant to this subsection to be used exclusively to establish a collection mechanism and to provide funding to update the Automated Traffic System Fund created pursuant to N.J.S.2B:12-30 to implement the provisions of this subsection.
The authority to impose additional fines and penalties under this subsection shall take effect 90 days after the effective date of P.L.2003, c.183 and shall expire five years thereafter. Not later than the 180th day prior to such expiration, the Attorney General shall prepare and submit to the Governor and the Legislature a report on the collection and use of DNA samples under P.L.1994, c.136. The report shall cover the period beginning on that effective date and ending four years thereafter. The report shall indicate separately, for each one-year period during those four years that begins on that effective date or an anniversary thereof, the number of each type of biological sample taken and the total cost of taking that type of sample, and also the number of identifications and exonerations achieved through the use of the samples. In addition, the report shall evaluate the effectiveness, including cost effectiveness, of having the samples available to further police investigations and other forensic purposes.

h. Notwithstanding the provisions of subsections a. and b. of this section, $1 shall be added to the amount of each fine and penalty imposed and collected under authority of any law for any violation of the provisions of Title 39 of the Revised Statutes or any other motor vehicle or traffic violation in this State and shall be forwarded by the person to whom the same are paid to the State Treasurer. The State Treasurer shall annually deposit those moneys so forwarded in the "New Jersey Brain Injury Research Fund" established pursuant to section 9 of P.L.2003, c.200 (C.52:9EE-9). The Administrative Office of the Courts may retain an amount equal to $475,000 from the moneys which it initially collects pursuant to this subsection, prior to depositing any moneys in the "New Jersey Brain Injury Research Fund," in order to meet the expenses associated with utilizing the Automated Traffic System Fund created pursuant to N.J.S.2B:12-30 to implement the provisions of this subsection and serve other statutory purposes.

C.52:9EE-10 Regulations.

11. The commission shall adopt regulations pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.) as are necessary to carry out the provisions of this act.

12. This act shall take effect on the 180th day following enactment.

## Appendix D

### RETURN TO ACADEMICS PROTOCOL
After Concussion/mild TBI

<table>
<thead>
<tr>
<th>STEPS</th>
<th>PROGRESSION</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>HOME—Total Rest</td>
<td>No mental exertion—Computer, Texting, Video games, or Homework. Stay at home. No driving.</td>
</tr>
<tr>
<td>2</td>
<td>HOME—Light Mental Activity</td>
<td>Up to 30 minutes mental exertion. No prolonged concentration. Stay at home. No driving.</td>
</tr>
</tbody>
</table>

Progress to next level when able to handle up to 30 minutes mental exertion without worsening of symptoms.

<table>
<thead>
<tr>
<th>3</th>
<th>SCHOOL—Part Time</th>
<th>Provide quiet place for scheduled mental rest. No significant classroom or standardized testing. Modify rather than postpone academics. Provide extra time, extra help, modified assignments.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Maximum Accommodations</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Shortened Day/Schedule</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Built-in Breaks</td>
<td></td>
</tr>
</tbody>
</table>

Progress to next level when able to handle 30-40 minutes mental exertion without worsening of symptoms.

<table>
<thead>
<tr>
<th>4</th>
<th>SCHOOL—Part Time</th>
<th>No standardized testing, Modified classroom testing. Moderate decrease of extra time, help, and modification of assignments.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Moderate</td>
<td>Accommodations</td>
</tr>
</tbody>
</table>

Progress to next level when able to handle 60 minutes mental exertion without worsening of symptoms.

<table>
<thead>
<tr>
<th>5</th>
<th>SCHOOL—Full Time</th>
<th>No standardized Testing, Routine tests OK. Continued decrease of extra time, help, and modification of assignments. May require more supports in academically challenging subjects.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Minimal Accommodations</td>
<td></td>
</tr>
</tbody>
</table>

Progress to next level when able to handle all class periods in succession without worsening of symptoms AND clearance for full return to athletics and academics.

<table>
<thead>
<tr>
<th>6</th>
<th>SCHOOL—Full Time</th>
<th>Attends all classes. Full homework.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Full Academics</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No accommodations</td>
<td></td>
</tr>
</tbody>
</table>

When symptoms continue beyond 3–4 weeks, Prolonged In-School Supports required. Request 504 meeting to plan and coordinate. If you have questions please contact Oregon’s TBI Coordinator at 877-972-7246.

### REMEMBER
Progression is individual; all concussions are different. Student may start at any step as symptoms dictate and remain at that step as long as needed. Return to previous step if symptoms worsen.

---

OCAMP
Oregon Concussion Awareness and Management Program
Appendix E

SAMPLE MILD TBI/CONCUSSION LEARNING ACCOMMODATIONS PLAN

Student Name: ___________________________ Date of Evaluation: ____________

As you know, the student named above has recently suffered a concussion and may have the following symptoms from the injury: headaches, nausea, fatigue, visual problems, balance problems, sensitivity to light or noise, dizziness, feeling mentally foggy, problems concentrating or remembering, irritability, sadness, nervousness, drowsiness and feeling easily overwhelmed. The signs and symptoms of a concussion can persist for days to weeks and can greatly affect learning. Sometimes symptoms may persist for months or longer. We ask you to please make the following accommodations to aid in the recovery process:

GENERAL RECOMMENDATIONS

☑ No school until specified, to be reviewed on _________________________
☑ Abbreviated daily class schedule (every other day, shortened day)
☑ No physical education classes (including weight training, aerobics, yoga)
☑ Consider reducing make-up work
☑ No testing (e.g., midterms, finals, standardized) during recovery period, until student is cleared

RECOMMENDATIONS FOR COGNITIVE ISSUES

☑ Provide extended time to complete assignments and/or shortened assignments
☑ Provide extended time to take tests in a quiet environment
☑ Provide a quiet environment to take tests
☑ Provide written instructions for homework
☑ Provide class notes by teacher or peer
☑ Allow utilization of notes for test taking due to memory issues
☑ Consider using tape recorder for note taking

RECOMMENDATIONS FOR FATIGUE/PHYSICAL ISSUES

☑ Allow time to visit school nurse for treatment of headaches or other symptoms, if needed
☑ Allow rest breaks during the day, if needed
☑ Allow “hall passing time” before or after the crowds have cleared
☑ Allow student to wear sunglasses indoors to control for light sensitivity
☑ Allow student to take lunch in quiet space to allow for rest and control for noise sensitivity

RECOMMENDATIONS FOR EMOTIONAL ISSUES

☑ Share progress and difficulties with parents, school nurse, counselor, physician, and athletic trainer
☑ Develop an emotional support plan for the student, this may include an adult with whom he/she can talk if feeling overwhelmed

If student symptoms require ongoing accommodations, consider contacting your district or building 504 coordinator to determine if a 504 plan would be beneficial. If symptoms last 45 days or more, contact your Oregon Regional TBI Liaison (tbiteam@wou.edu).

Oregon Concussion Awareness and Management Program
Appendix F

Returning to School After Concussion: Recommended Protocol
Return to School Protocol: Purpose

A concussion is a mild form of traumatic brain injury (mTBI), caused by a bump, blow, or jolt to the head, which can induce an altered state, including physical and cognitive abilities. It may or may not include loss of consciousness; however, typically, there is no loss of consciousness. Concussion is a functional rather than a structural disturbance that may need short- or long-term management. In the hours and days post-concussion, metabolic and chemical changes take place within the brain at the cellular level, resulting in physical, cognitive, and/or emotional symptoms. Activities associated with academics can significantly increase symptoms, even when the student has begun to recover. Total cognitive and physical rest is typically recommended for the first several days to weeks. The effects of a concussion may linger for several months to a year or more.

The purpose of this Return to School Protocol is to assist local educational agencies (LEAs) in understanding the importance of monitoring a student’s return to academics following a concussion. The Return to School Protocol is voluntary and may be used at the discretion of the LEA. A referral to the BrainSTEPS Program should be made if a student is 4 weeks post-concussion and is still experiencing symptoms, or if the student’s classroom performance or attendance has been impacted. Referrals to BrainSTEPS can be made earlier if:

› A student has a concussion that is not progressively resolving during the first few weeks, or

› A student has a history of any of the following “concussion modifiers”:
  • Post concussion(s)
  • Migraine headaches
  • Depression or other mental health issues
  • Attention deficit hyperactivity disorder (ADHD)
  • A learning disability
  • Sleep disorders

BrainSTEPS can:

› Assist with implementation of the Return to School Protocol

› Train staff at the district, school or classroom level on the effects of concussion

› Provide consultation to school personnel and parents for referred students at 4 weeks post-concussion, or earlier if needed

› Provide symptom specific educational accommodations utilizing the Brain injury Supports Framework

› Assist in ongoing monitoring of symptoms and accommodations until the concussion resolves

› Facilitate communication between family, student, medical, and educational entities

All students who experience a concussion should be medically evaluated and should follow the treatment recommended by a medical professional with experience in managing concussions.

LEAs utilizing this voluntary Return to School Protocol are asked to designate two individuals at either the district or individual school building level who will agree to monitor the student and the resulting educational impact on the student after the concussion. These two individuals will serve as the Concussion Management Team (CMT). The CMT is comprised of individuals who can serve as the Academic Monitor and the Symptom Monitor. Together, the CMT will promote information flow between the school team, family, student, and physician.

Initial 4 Weeks Post-Concussion: LEA Responsibilities

1. The LEA learns that a student has sustained a concussion.

2. The Concussion Management Team (CMT) is notified.

3. The CMT notifies the student’s educators, alerting them of the concussion and the student’s need for rest and academic accommodations. The CMT will:
• Share the physician's instructions with relevant school staff, as well as recommendations provided by the parents.

• Include the student's specific symptoms, along with adjustments/accommodations to alleviate exacerbating symptoms.

• Notify the coach, the athletic director, and the athletic trainer, if the student is an athlete.

• Provide notification to appropriate school staff that the student should be excused from physical education class, sports, and physical activity during recess until cleared.

4. The CMT's Symptom Monitor will utilize the BrainSTEPS Student Symptom Severity Monitoring Checklist to monitor the student's physical, thinking/remembrance, and emotional symptoms. Symptoms should be monitored via student interview 3 to 5 days per week for the first 2 weeks, and then 2 to 3 days per week during weeks 3 and 4.

5. The CMT's Academic Monitor will monitor the student's weekly performance, both academically and behaviorally, by having all relevant teaching staff complete the BrainSTEPS Academic Monitoring Form at the conclusion of each week until symptoms resolve.

6. Weekly, the Academic Monitor and Symptom Monitor will meet to review results of the Symptom Severity Monitoring Checklist and the Academic Monitoring Tool, to determine whether further accommodations should be made during the initial 4 weeks or if the concussion symptoms and impacts have resolved and CMT monitoring and accommodations are no longer needed. Weekly results will be shared with the student's teachers, related professionals, and parents/guardians.

• Parents/guardians should be involved in providing input on symptoms occurring at home.

• Accommodations for coursework should be provided until all symptoms resolve. Physical symptoms (e.g., headache, dizziness, light/noise sensitivity) may heal faster than cognitive symptoms (e.g., attention, memory, concentration).

7. It is recommended that the CMT offer support and educational resources to the student's parents. One such resource is:

   The Centers for Disease Control and Prevention: www.cdc.gov
   (Type "concussion" in the search box.)

At 4 Weeks Post-Concussion: BrainSTEPS Referral

1. If the student remains symptomatic and/or there has been a notable change in student performance or attendance, the Concussion Management Team (CMT) will initiate a formal referral to the BrainSTEPS Program by visiting the BrainSTEPS website (www.brainsteps.net) to locate the correct consulting team by county.

2. BrainSTEPS will conduct student specific concussion training for relevant school staff, parents/guardians, and student.

3. The CMT will schedule a BrainSTEPS Brain Injury Supports Framework meeting, including all relevant parties (school team, parent/guardian, student, BrainSTEPS).

4. BrainSTEPS will partner with the CMT, school team, parent/guardian, and student to create an individualized BrainSTEPS Brain Injury Supports Framework during this meeting.

   • Results from all weekly BrainSTEPS Academic Monitoring Tools collected by the Academic Monitor to date will be shared with BrainSTEPS prior to the meeting.

   • Results from all weekly BrainSTEPS Student Symptom Severity Monitoring Checklists collected by the Symptom Monitor to date and any physician medical instructions will be shared with BrainSTEPS prior to the meeting.

   • During the initial BrainSTEPS Brain Injury Supports Meeting, a follow-up meeting within 1 month will be scheduled to review, modify, continue, or conclude accommodations.

   continued . . .
• The Academic Monitor will provide a final copy of the BrainSTEPS Brain Injury Supports Framework to relevant school staff and parents/guardians.

• If the student is receiving homebound instruction, the BrainSTEPS Brain Injury Supports Framework should be shared with the teachers assigning and providing homebound instruction.

5. The Symptom Monitor will continue to monitor the student’s symptoms 2 to 3 days per week using the BrainSTEPS Student Symptom Severity Monitoring Checklist. The Symptom Monitor will provide copies of the Monitoring Checklist to BrainSTEPS prior to any formal review of the BrainSTEPS Brain Injury Supports Framework.

6. The Academic Monitor will continue to monitor the student’s academics weekly using the BrainSTEPS Academic Monitoring Tool. The Academic Monitor will provide copies of the Academic Monitoring Tool to BrainSTEPS prior to any formal review of the BrainSTEPS Brain Injury Supports Framework.

• The Academic Monitor will provide a final copy of the BrainSTEPS Brain Injury Supports Framework to relevant school staff and parents each time it is modified.

4-8 Weeks Post-Concussion if Symptoms Persist

1. If the student continues to be symptomatic, the Concussion Management Team, BrainSTEPS, and school personnel should consider whether the student’s academic or behavioral needs warrant ongoing adjustments and accommodations, or if an evaluation should be conducted by the LEA to determine the need for more formal intensive accommodations and/or modifications.

2. If a referral for a multipurpose evaluation is not deemed necessary, then continued monitoring by the CMT and monthly review of the Brain injury Support Framework, in partnership with BrainSTEPS, will continue.

3. If further formal educational supports are thought to be necessary, a referral for a multipurpose evaluation should be made to the appropriate individual at the district level.

4-8 Weeks Post-Concussion if Symptoms Resolve

1. BrainSTEPS will work with the Concussion Management Team (CMT), school team, parent/guardian, and student to determine appropriate accommodations and modifications until the symptoms impacting education resolve. Resolution of symptoms could take weeks, months, and in some cases symptoms may last a lifetime.

2. If the symptoms impacting education completely resolve, there should be a meeting held by the LEA to conclude the implementation of the BrainSTEPS Brain Injury Supports Framework or more formal accommodation agreement.

• CMT monitoring will conclude.

• All relevant school staff, as well as the student and the student’s parent/guardian will be notified by the LEA.

3. The LEA will ensure that the concussion has been noted in the student’s educational record on file with the district.

For more information about BrainSTEPS contact:

Brenda Eagan Brown, MSED, CRS, BrainSTEPS Program Coordinator
Email: eaganbrown@biapa.org
Phone: 724-944-6542
Appendix G

NEW JERSEY CONCUSSION LAW - P.L.2010, c.94  
CHAPTER 94

AN ACT concerning the health of student-athletes and supplementing P.L.1984, c.203 (C.45:9-37.35 et seq.) and chapter 40 of Title 18A of the New Jersey Statutes.

BE IT ENACTED by the Senate and General Assembly of the State of New Jersey:

C.18A:40-41.1 Findings, declarations relative to head injuries of student athletes.  
1. The Legislature finds and declares that:
   a. A concussion is caused by a blow or motion to the head or body that disrupts the normal functioning of the brain, and can cause significant and sustained neuropsychological impairments including, but not limited to, problem solving, planning, memory, and behavioral problems;
   b. The federal Centers for Disease Control and Prevention estimates that 300,000 concussions are sustained during sports-related activity in the United States, and more than 62,000 concussions are sustained each year in high-school contact sports;
   c. Although concussions are one of the most commonly reported injuries in children and adolescents who participate in sports and recreational activities, little effort and resources have been committed to inform athletes, coaches, and parents and guardians about the causes and symptoms of concussions;
   d. If a person sustains a second concussion while still having symptoms of a previous concussion, it can lead to the severe impairment and even the death of the victim, and is referred to as second-impact syndrome; and
   e. In order to ensure the safety of student-athletes, it is imperative that athletes, coaches, and parents and guardians are educated about the nature and treatment of concussions and other sports-related head injuries, and that all measures are taken to prevent a student-athlete from experiencing second-impact syndrome.

C.18A:40-41.2 Interscholastic athletic head injury safety training program.  
2. a. The Department of Education shall work to develop and implement, by the 2011-2012 school year, an interscholastic athletic head injury safety training program. The program shall be completed by a school physician, a person who coaches a public school district or nonpublic school interscholastic sport, and an athletic trainer involved in a public or nonpublic school interscholastic sports program. The safety training program shall include, but need not be limited to, the following:
   (1) the recognition of the symptoms of head and neck injuries, concussions, and injuries related to second-impact syndrome; and
   (2) the appropriate amount of time to delay the return to sports competition or practice of a student-athlete who has sustained a concussion or other head injury.
   b. The department shall update the safety training program as necessary to ensure that it reflects the most current information available on the nature, risk, and treatment of sports-related concussions and other head injuries.
c. The department shall develop an educational fact sheet that provides information about sports-related concussions and other head injuries. A school district or a nonpublic school that participates in an interscholastic sports program shall distribute the educational fact sheet annually to the parents or guardians of student-athletes and shall obtain a signed acknowledgment of the receipt of the fact sheet by the student-athlete and his parent or guardian.

C.18A:40-41.3 Written policy for school district concerning prevention, treatment of sports-related head injuries.

3. a. Each school district shall develop a written policy concerning the prevention and treatment of sports-related concussions and other head injuries among student-athletes. The policy shall include, but need not be limited to, the procedure to be followed when it is suspected that a student-athlete has sustained a concussion or other head injury. When developing the district policy, a school district shall review the model policy established by the Commissioner of Education pursuant to subsection b. of this section, the policies established by the New Jersey State Interscholastic Athletic Association, the National Collegiate Athletic Association, and the recommendations made by the Brain Injury Association of New Jersey Concussion in Sports Steering Committee, the Athletic Trainers’ Society of New Jersey, and other organizations with expertise in the area of preventing or treating sports-related concussions and other head injuries among student-athletes. Each school district shall implement the policy by the 2011-2012 school year.

The policy shall be reviewed annually, and updated as necessary, by the district to ensure that it reflects the most current information available on the prevention, risk, and treatment of sports-related concussions and other head injuries.

b. To assist school districts in developing policies concerning the prevention and treatment of sports-related concussions and other head injuries among student-athletes, the Commissioner of Education shall develop a model policy applicable to grades kindergarten through 12. This model policy shall be issued no later than March 31, 2011.

C.18A:40-41.4 Removal of student athlete from competition, practice; return.

4. A student who participates in an interscholastic sports program and who sustains or is suspected of having sustained a concussion or other head injury while engaged in a sports competition or practice shall be immediately removed from the sports competition or practice. A student-athlete who is removed from competition or practice shall not participate in further sports activity until he is evaluated by a physician or other licensed healthcare provider trained in the evaluation and management of concussions, and receives written clearance from a physician trained in the evaluation and management of concussions to return to competition or practice.

C.18A:40-41.5 Immunity from liability.

5. a. A school district and nonpublic school shall not be liable for the injury or death of a person due to the action or inaction of persons employed by, or under contract with, a youth sports team organization that operates on school grounds, if the youth sports team organization provides the district or nonpublic school, as applicable, with the following:
(1) proof of an insurance policy of an amount of not less than $50,000 per person, per occurrence insuring the youth sports team organization against liability for any bodily injury suffered by a person; and

(2) a statement of compliance with the school district or nonpublic school’s policies for the management of concussions and other head injuries.

b. As used in this section, a “youth sports team organization” means one or more sports teams organized pursuant to a nonprofit or similar charter or which are member teams in a league organized by or affiliated with a county or municipal recreation department.

C.45:9-37.48a Continuing education requirement for athletic trainer.

6. a. The State Board of Medical Examiners shall require each person licensed as an athletic trainer, as a condition for biennial license renewal pursuant to section 14 of P.L.1984, c.203 (C.45:9-37.48), to complete 24 credits of continuing athletic trainer education, which shall include a specific number of credits of instruction on topics related to concussions and head injuries, as determined by the State Board of Medical Examiners.

b. The board shall:

(1) establish standards for continuing athletic trainer education, including the subject matter and content of courses of study; and

(2) accredit education programs offering credit toward continuing athletic trainer education requirements or recognize national or State organizations that may accredit education programs.

c. Each hour of an educational course or program shall be equivalent to one credit of continuing athletic trainer education.

d. The board may, in its discretion, waive requirements for continuing athletic trainer education on an individual basis for reasons of hardship such as illness or disability, retirement of license, or other good cause. A waiver shall apply only to the current biennial renewal period at the time of board issuance.

e. The board shall not require completion of continuing athletic trainer education credits for any licensure period commencing within 12 months of the effective date of this section.

f. The board shall require completion of athletic trainer education credits on a pro-rated basis for any registration period commencing more than 12 months but less than 24 months from the effective date of this section.

g. Prior to license renewal, each licensee shall submit to the board proof of completion of the required number of hours of continuing athletic trainer education.

7. Sections 1 through 5 of this act shall take effect immediately and section 6 shall take effect on the 360th day after the date of enactment.

Approved December 7, 2010.
Appendix H

NEW JERSEY ADVISORY COUNCIL ON TBI AND THE TBI FUND - P.L.2001, c.332
CHAPTER 332

AN ACT concerning traumatic brain injury, amending P.L.1992, c.87 and supplementing Title 30 of the Revised Statutes.

BE IT ENACTED by the Senate and General Assembly of the State of New Jersey:

C.30:6F-1 Findings, declarations relative to traumatic brain injury.
1. The Legislature finds and declares that:
   a. The Brain Injury Association of New Jersey has identified traumatic brain injury as the leading cause of death and disability among children and young adults in this country;
   b. Since the late 1970's, advances in medical technology have enabled many persons with severe brain injury to survive these injuries;
   c. Persons with brain injury may need specialized rehabilitation programs and other services geared to the specific needs of these individuals in order to live their lives to the maximum potential;
   d. Most forms of insurance, both public and private, that are available to people with brain injury do not cover the rehabilitative and long-term care needs of these individuals;
   e. People with brain injury and their families too often must choose between financial hardship and discontinuing critical treatment and services due to the substantial long term costs not paid for by their insurance coverage; and
   f. Providing treatment methods and services to people with brain injury must be a priority for the State.

C.30:6F-2 Definitions relative to traumatic brain injury.
2. As used in this act:
   "Council" means the New Jersey Advisory Council on Traumatic Brain Injury established pursuant to section 3 of this act; and
   "Fund" means the Traumatic Brain Injury Fund established pursuant to section 5 of this act.

3. a. There is established in the Department of Human Services the New Jersey Advisory Council on Traumatic Brain Injury.
   b. The council shall be composed of 26 members as follows: the Commissioners of Human Services, Education, Health and Senior Services, Community Affairs, Labor and Banking and Insurance, the Attorney General and the State Treasurer, or their designees, who shall serve ex officio and 18 public members, who shall be appointed by the Governor, with the advice and consent of the Senate. Of the public members, eight shall be survivors of traumatic brain injury or the family members of these persons and at least five shall be representatives of the following groups: public or private health-related organizations, disability advisory or planning groups within the State, the Brain Injury Association of New Jersey, injury control programs at the State or local level, and the Center for Health Statistics in the Department of Health and Senior Services for data research purposes.
c. Public members shall serve for a term of three years from the date of their appointment and until their successors are appointed and qualified; except that of the members first appointed, six shall serve for a term of one year, six shall serve for a term of two years and six shall serve for a term of three years. Vacancies shall be filled for the balance of the unexpired term in the same manner as the original appointments were made. A member of the council shall be eligible for reappointment.

d. The public members who are serving on the New Jersey Advisory Council on Traumatic Brain Injury established by Executive Order No. 84 of 1998, on the effective date of this act may complete the duration of their term as members of the council established pursuant to this act and are eligible for appointment to the council established pursuant to this act.

e. The members of the council shall meet quarterly and the Commissioner of Human Services, or his designee, shall serve as chair of the council.

f. The members of the council shall serve without compensation, but shall be reimbursed for necessary and reasonable expenses actually incurred in the performance of their duties, within the limits of funds appropriated or otherwise made available to the council for this purpose.

C.30:6F-4 Duties of council.

4. The council shall:

a. Advise and make recommendations to the Department of Human Services and other related State agencies on ways to improve and develop services regarding traumatic brain injury, including the coordination of these services between public and private entities;

b. Encourage citizen participation through the establishment of public hearings and other types of community outreach and prevention activities;

c. Encourage and stimulate research, public awareness, education and prevention activities;

d. Oversee any programs created under the federal law, Pub. L.104-166, known as the Traumatic Brain Injury Act, and any successive amendments to that act, and report to the federal government regarding these programs; and

e. Advise the Commissioner of Human Services on the administration of the Traumatic Brain Injury Fund established pursuant to section 5 of this act.

C.30:6F-5 "Traumatic Brain Injury Fund."

5. a. There is established in the Department of the Treasury a nonlapsing, revolving fund to be known as the "Traumatic Brain Injury Fund." This fund shall be the repository for monies provided pursuant to subsection b. of section 1 of P.L.1992, c.87 (C.39:3-8.2) and any other funds approved by the Department of Human Services or the council.

b. The State Treasurer is the custodian of the fund and all disbursements from the fund shall be made by the State Treasurer upon vouchers signed by the Commissioner of Human Services or his designee. The monies in the fund shall be invested and reinvested by the Director of the Division of Investment in the Department of the Treasury as are other trust funds in the custody of the State Treasurer, in the manner provided by law. Interest received on the monies in the fund shall be credited to the fund.

C.30:6F-6 Distribution of monies.

6. a. Monies in the Traumatic Brain Injury Fund shall be distributed by the Department of Human Services for the following purposes:
(1) as the payer of last resort, for the costs of post-acute care, services and financial assistance provided in this State to residents of this State who have survived neuro-trauma with a traumatic brain injury; and

(2) public information and prevention education coordinated by the Brain Injury Association of New Jersey.

b. The department, in consultation with the council, shall establish eligibility criteria for the post-acute care, services and financial assistance provided pursuant to this section. Expenditures for traumatic brain injury care shall be made by the department.

(1) Total expenditures on behalf of any one eligible person shall not exceed $100,000, with no more than $15,000 to be expended for any 12-month period; except that a person may apply to the department for a waiver of these expenditure limits.

(2) Expenditures shall be made only if comparable resources are not available or are not able to be delivered in a timely manner.

(3) To the extent of the assistance it has provided, the fund shall have first claim to any future monies received by the person with traumatic brain injury as the result of a settlement or other payment made in connection with the traumatic brain injury.

(4) In the event the department is unable to provide funds to all eligible persons, the department, in consultation with the council, may establish an order of selection.

c. The department shall accept applications for disbursements of available money from the fund and maintain records of all disbursements made from the fund and monies received as gifts and donations. The department shall utilize existing State resources and staff of participating State agencies, businesses and nonprofit organizations whenever practicable.

C.30:6F-7 Annual report on status of fund.

7. The Department of Human Services shall report annually on the status of the fund to the Governor and to the Senate and General Assembly committees with responsibility for issues affecting health or human services. The report shall include information about the number of beneficiaries of the fund, average expenditures per beneficiary and the average income and expenditures of persons or families who received financial assistance from the fund. The department also may make recommendations for changes in the law and any regulations governing the fund.

C.30:6F-8 Rules, regulations.

8. The Commissioner of Human Services, pursuant to the "Administrative Procedure Act," P.L.1968, c.410 (C.52:14B-1 et seq.), may adopt rules and regulations necessary to effectuate the purposes of this act.

9. Section 1 of P.L.1992, c.87 (C.39:3-8.2) is amended to read as follows:

C.39:3-8.2 Additional fees.

1. a. In addition to the motor vehicle registration fees imposed pursuant to the provisions of chapter 3 of Title 39 of the Revised Statutes, the director shall impose and collect an additional fee of $1 to be deposited in the New Jersey Emergency Medical Service Helicopter Response Program Fund created pursuant to section 2 of P.L.1992, c.87 (C.26:2K-36.1).

b. In addition to the motor vehicle registration fees imposed pursuant to the provisions of chapter 3 of Title 39 of the Revised Statutes, the director shall impose and collect an additional
fee of $.50 to be deposited in the Traumatic Brain Injury Fund established pursuant to section 5 of P.L.2001, c.332 (C.30:6F-5).

10. This act shall take effect immediately; provided, however, that section 9 shall remain inoperative until the first day of the sixth month following enactment.

Approved January 5, 2002.