



CONCUSSION "RETURN TO LEARN" / PHYSICIAN RECOMMENDED SCHOOL ACCOMMODATIONS

Student Name: _____ Date of Birth: _____ Date of Evaluation: _____

This patient has been diagnosed with a concussion (brain injury) and is currently under our care. Please excuse from school during appointment time. Flexibility and support are needed during recovery. The following are suggested academic adjustments to be individualized for this student, as deemed appropriate in the school setting.

Anticipated Symptoms: Sensitivity to: Light Sound; Difficulty with: Sleep Concentration Memory Balance
 Irritability Headache Dizziness Visual problems Nausea Feeling foggy Fatigue

Area	Requested Modifications [check applicable boxes <input type="checkbox"/>	Comments
Attendance	<input type="checkbox"/> <u>Standard Recommendations:</u> No school for 24 hours after concussion; Once student tolerates a 15 minute walk without symptoms, can begin school. Start with half-day school and then progress to full days, as tolerated. <input type="checkbox"/> Dismiss student before/after class to avoid crowds	
Observation	<input type="checkbox"/> School staff to help identify aggravators, to reduce exposure (<i>e.g., bright lights, noisy hallways, attention to school work longer than 20 minutes</i>)	
Breaks	<input type="checkbox"/> Anticipate breaks during school day <input type="checkbox"/> Mandatory breaks every: _____ <input type="checkbox"/> If symptoms appear/worsen during class, allow rest in nurse's office; If no improvement after 30 minutes, allow dismissal to home <input type="checkbox"/> Water bottle in class / Snack every 3-4 hours	
Visual Stimuli	<input type="checkbox"/> Allow sunglasses/Hat <input type="checkbox"/> Audiotapes (vs. books/computer) <input type="checkbox"/> Larger font for written materials <input type="checkbox"/> Change classroom seating, as needed <input type="checkbox"/> Pre-printed class notes or note taker <input type="checkbox"/> Limit time and/or brightness of monitors/screens	
Auditory Stimuli	<input type="checkbox"/> Avoid loud classroom activities, music/band, wood/metal shop, choir, gym <input type="checkbox"/> Lunch and recess in quiet place (with a friend) <input type="checkbox"/> Allow to wear earplugs, as needed <input type="checkbox"/> Allow class transitions before bell	
School work and Testing	<input type="checkbox"/> Simplify tasks and instructions <input type="checkbox"/> Reduce in-class work <input type="checkbox"/> Reduce homework (____ minutes max total, per night) <input type="checkbox"/> No homework <input type="checkbox"/> No testing <input type="checkbox"/> No standardized tests <input type="checkbox"/> Allow additional time to take test <input type="checkbox"/> Alternative test methods (oral delivery, oral response, scribe) <input type="checkbox"/> Maximum one test per day	
Physical Activity	<input type="checkbox"/> No exertive physical activity until academically back to normal [For maximum of 2 weeks; then individualize as per rehab specialist] <u>Follow the attached Return to Play protocol:</u> <input type="checkbox"/> General activity <input type="checkbox"/> CIF form <input type="checkbox"/> Sport specific	

PARENT/GUARDIAN: I give permission for the exchange of information between the school and my child's physician for matters related to school accommodations following a concussion, allowing changes to this plan.

Name: _____ Signature: _____ Date: _____

This patient will be reassessed here for revision of these recommendations in _____ weeks/days. Please have a school representative send me (and parent) periodic updates on functioning in school, until student back to normal.

Physician Name (printed or stamp) Physician Address (or stamp) Physician Signature Date