**CAMP HILL CONCUSSION MANAGEMENT TEAM**

**PHYSICIAN ACCOMODATION FORM**

Student/Athlete Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Injury:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Initial Exam:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sport:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Concussion Monitor Contact:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Concussion Monitor Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* After reviewing the attached medical facts, it is my opinion that the student **DID NOT** sustain a concussion on the above date noted and is released to play in the above sport.
* The above named student **HAS SUSTAINED A CONCUSSION** on the date of injury noted and should not return to participation in athletics until school district return to play criteria have been met. The student’s progress through the stages will be monitored by a Certified Athletic Trainer and/or Nurse.

**Until the above name student has fully recovered, the following academic accommodations are recommended**: *(check all that apply)*

\_\_\_ No return to school. Return on (date)

\_\_\_ Shortened day. Recommend \_\_\_\_ hours per day until (date)

\_\_\_ Shortened classes (i.e. rest breaks during classes. Maximum class length \_\_\_\_minutes

\_\_\_ No PE class until further notice

\_\_\_ Restricted PE class-Should not participate in activity that would put student at risk for head injury

\_\_\_ Allow extra time to complete coursework, assignments, and tests

\_\_\_ Modify homework assignments

\_\_\_ Temporarily excuse student from class that may be over stimulating due to light/noise

\_\_\_ No note taking. Provide student with teacher generated notes

\_\_\_ No significant classroom or standardized testing at this time

\_\_\_ Take rest breaks during the day as needed

\_\_\_ Other (please specify)

By signing below, I hereby certify that I am **familiar with current concussion management and I can certify that all aspects of evaluation, treatment, and risk of that injury have been thoroughly covered with the student.**

Physician Name (printed)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician Signature (Must be MD or DO)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physicians Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physicians Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FORM MUST BE SIGNED BY MD OR DO. NO OTHER SIGNATURES WILL BE ACCEPTED**