Pierce County Medical Society

RETURN TO SCHOOL AFTER CONCUSSION

STUDENT NAME: _____ **DOB**: _____

SCHOOL: _____ **GRADE**: _____

DATE OF CONCUSSION: _____

A concussion is a mild injury to the brain that temporarily changes how the brain normally works. It is usually caused by a sudden blow or jolt to the head, although children often bump or hit their heads without getting concussions. Signs and symptoms of a concussion include dizziness, headache, vomiting, confusion, acting dazed, forgetting what happened before or after the injury, and being "knocked out." A person does NOT need to be knocked out or lose consciousness to have had a concussion. Other words or terms for a concussion include mild traumatic brain injury (mild TBI) and mild closed-head injury.

Student may return to school on _____
(DATE)

PHYSICAL ACTIVITY:

- ☐ Student is **FULLY** limited and can NOT participate in any activities
- ☐ Student is **PARTIALLY** limited and can participate in the following activities only: _____
  _____
- ☐ YES, Student can return to RECESS and PE activities
- ☐ Student has **NO** limitations and can return to full participation

ACADEMIC ACTIVITY:

- ☐ Student may return to full participation without limitations.
- ☐ The following cognitive accommodations are recommended for this student:
  - ☐ Gradual re-integration to school (e.g., student returns part-time before resuming a full schedule)
  - ☐ Student not asked to do all missed work
  - ☐ Rest time or breaks as needed during the day
  - ☐ Overall homework and class work load reduced
  - ☐ No use of computer or other video equipment until after _____ (DATE)
  - ☐ No testing until after _____ (DATE)
  - ☐ Other: _____

Student has been counseled on how to self-manage this concussion: ☐ YES ☐ NO

Student may resume full participation in all activities after _____ (DATE)

Student is to be re-evaluated on _____ (DATE) **and may NOT resume full participation until cleared.**

Health care provider comments:

_____ _____ _____
Health Care Provider's Signature | Telephone | Fax

_____ _____
Health Care Provider's Printed Name or Stamp | Date

Routing:

Parent	Trans	Nurse	Teacher	PE	SPEC	HRA	Kitchen	Sec-Principal

4/2011