Concussion Form
Villa Maria High School

Name:_____ Grade:_____ Date of Birth:_____

Duration of Recommendations: 1 Week 2 Weeks 3 Weeks

The student will be reassessed for revision of these recommendations on: _____

This student has been diagnosed with a concussion (a brain injury) and is currently under care. Flexibility and additional support are needed during recovery. The following are suggestions for academic adjustments to be individualized for the student as deemed appropriate in the school setting.

Please check which applies your patient:

_____ No school for_____school day(s)

_____ Full school days as tolerated by the student

_____Half days until_____

Attendance

Visual Stimulus

_____Allow student to wear sunglasses in school

_____ Limited computer, TV screen, bright screen use.

_____ Change classroom seating as necessary

Workload/Multi-Tasking

_____ Reduce overall amount of make-up work, classwork, and homework

_____ Prorate workload when possible

_____ Reduce amount of homework given each night

Physical Exertion

_____ No physical exertion/athletics/gym/dance class

_____ Walking in gym class only

_____ Begin Return to Play protocol as per Athletics

_____ No participation in dances, prom, pep rallies and assemblies

Breaks

_____ Allow the student to go to the nurse's office if symptoms increase

_____ Allow student to go home if symptoms do not subside

_____ Allow other breaks during school day as deemed necessary and appropriate by school personnel

Audible Stimulus

_____ Lunch in a quiet place with a friend

_____ Avoid music

_____ Allow to wear earplugs as needed

_____Allow class transitions before bell

Testing

_____ Additional time to complete tests

_____ No more than one test a day

_____ No standardized testing until _____

_____ Allow for scribe, oral response, and oral delivery of questions, if available

Additional Recommendations

_____

_____

_____

Current Symptoms

_____Headache _____Visual problems _____Sensitivity to noise _____Memory issues

_____Nausea _____Balance problems _____Feeling foggy _____Fatigue

_____Dizziness _____Sensitivity to light _____Difficulty concentrating _____Irritability

Physician's Signature_____Date:_____