Darien Public Schools #61
Return to Learn Form

To be completed by physician

Student Name: _____ Date of Birth: _____

Concussion Date: _____

Darien Public Schools District #61 has created a Concussion Oversight Team that includes: the district nurse, school administrator, counselor, teacher, coach and medical professionals to assist the student diagnosed with a concussion in returning to the classroom. This team will be in contact with all the students' teachers regarding the needs of the student's Return to Learn protocol. Please complete the below information to assist the team in their efforts (if a different letter or form contains extra information, please write: "*see attached"):*_____.

Return to Learn

Upon returning to school the student requires the following modifications, for a duration of: _____.

Modification (check modification required)	**How long modified**	**Comments**
___No academic modifications, student may progress to Return To Play protocol as appropriate.	N/A	
___Half day of school		
___No standardized testing (MAP, PARCC)		
___No classroom testing		
___ Early release from class		
___Preferential seating based on light/sound sensitivities		
___ Reduced workload (indicate percent modified)	% modified = _____	
___Classroom notes from teacher		
___Quiet rest time during the day (duration/frequency)		Duration = _____ Frequency =_____
_____ PE/Recess accommodations		
_____ Extracurricular activities (i.e. sports, band)		

Physician Signature: _____ Date: _____

Physician Name: _____ **Phone number:** _____

revised 9/16 ts

To be completed by parent:

1) I have reviewed and agree with the learning accommodations recommended by my child's medical provider as part of his/her Return to Learn protocol.

_____

Parent Signature Date

2) I, the undersigned, do hereby authorize _____(*insert provider name & title*), Phone:_____ Address: _____ to disclose and/or exchange concussion related medical and educational information regarding the above named student with:

SCHOOL: [ ] Mark DeLay School	[ ] Lace School	[ ] Eisenhower Jr. High
6801 Wilmette Ave.	7414 S. Cass Ave.	1410 75th Street
Darien, IL 60561	Darien, IL 60561	Darien, IL 60561
630-852-0200 phone	630-968-2589 phone	630-964-5200 phone
630-968-7506 fax	630-968-5920 fax	630-968-8002 fax

School Contact Person:

_____

(*insert name/title of school official*)

This authorization is valid for one year. It will expire on (insert date or event): _____. I understand that I may revoke this authorization at any time by submitting written notice of the withdrawal of my consent. Health records, once received by the school district, may not be protected by the HIPAA Privacy Rule, but will become education records protected by the Family Educational Rights and Privacy Act. I also understand that if I refuse to sign, such refusal will not interfere with my child's ability to obtain health care.

_____ _____

Parent Signature Date