

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

Current Symptoms

- | | | | |
|-----------------|----------------------------|--------------------------------|---------------------|
| _____ Headache | _____ Visual problems | _____ Sensitivity to noise | _____ Memory issues |
| _____ Nausea | _____ Balance problems | _____ Feeling foggy | _____ Fatigue |
| _____ Dizziness | _____ Sensitivity to light | _____ Difficulty concentrating | _____ Irritability |

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

Physician's Signature _____ Date: _____