Physician Letter to School

To Whom It May Concern:

Student Name: _____ DOB: _____

INJURY STATUS	***Date of Concussion Diagnosis by MD/DO:*** _____ ***Date of Injury:*** _____

__ Has been diagnosed by a MD/DO with a concussion and is currently under our care.
Medical follow-up evaluation is scheduled for *(date)*: _____

__ Was evaluated and did not have a concussion injury. There are no limitations on school and physical activity.

ACADEMIC ACTIVITY STATUS *(Please mark all that apply)*

__ **This student is not to return to school.**

__ This student may begin to return to school based on graduated progression through the ***CIF Concussion Return to Learn Protocol.***

__ This student requires the necessary school accommodations set forth on the ***Physician (MD/DO) Recommended School Accommodations Following Concussion*** form.

__ This student may be released to full academic participation.

Comments: _____

PHYSICAL ACTIVITY STATUS *(Please mark all that apply)*

__ **This student is not to participate in physical activity of any kind.**

__ This student is not to participate in recess or other physical activities except for untimed, voluntary walking.

__ This student may begin a graduated return to play progression (see ***CIF Concussion RTP Protocol*** form).

__ This student has medical clearance for unrestricted athletic participation (Has completed the ***CIF Concussion RTP Protocol***).

Comments: _____

Physician *(MD/DO)* **Signature**: _____ **Exam Date**: _____

Physician Stamp and Contact Info:

Parent/Guardian Acknowledgement Signature: _____ **Date**: _____

Physician (MD/DO) Recommended School Accommodations Following Concussion

Patient Name: _____ Date: _____

I, _____, give permission for the physician to share the following information with my child's school and for communication to occur between the school and physician for changes to this plan. Parent Signature: _____

The patient will be reevaluated for revision of these recommendations in _____ weeks. Date of Injury: _____ Date of Concussion Dx: _____

Physician Name/Signature: _____ Exam Date: _____

This student has been diagnosed with a concussion (a brain injury) and is currently under our care. Please excuse the student from school today due to the medical appointment. Flexibility and additional support are needed during recovery. The following are suggestions for academic accommodations to be individualized for the student as deemed appropriate in the school setting. *Accommodations can be modified as the student's symptoms improve/worsen.*

Please see the CIF Return to Learn Protocol for more information (cifstate.org).

Area	Requested Modifications	Comments/ Clarifications
Attendance	☐ No School ☐ Partial School day as tolerated by student – emphasis on core subject work *Encouraged Classes:* _____ *Discouraged Classes:* _____ ☐ Full School day as tolerated by student ☐ Water bottle in class/snack every 3-4 hours	
Breaks	☐ If symptoms appear/ worsen during class, allow student to go to quiet area or nurse's office; if no improvement after 30 minutes allow dismissal to home ☐ *Mandatory Breaks:* _____ ☐ Allow breaks during day as deemed necessary by student or teachers/school personnel	
Visual Stimulus	☐ Enlarged print (18 font) copies of textbook material / assignments ☐ Pre-printed notes (18 font) or note taker for class material ☐ Limited computer, TV screen, bright screen use ☐ Allow handwritten assignments (as opposed to typed on a computer) ☐ Allow student to wear brimmed hat in school; seat student away from windows and bright lights ☐ Reduce brightness on monitors/screens ☐ Change classroom seating to front of room as necessary	
Auditory Stimulus	☐ Avoid loud classroom activities ☐ Lunch in a quiet place with a friend ☐ Avoid loud classes/places (i.e. music, band, choir, shop class, gym and cafeteria) ☐ Allow student to wear earplugs as needed ☐ Allow class transitions before the bell	
School Work	☐ Simplify tasks (i.e. 3 step instructions) ☐ Short breaks (5 minutes) between tasks ☐ Reduce overall amount of in-class work ☐ Prorate workload (only core or important tasks) /eliminate non-essential work ☐ No homework ☐ Reduce amount of nightly homework _____ *minutes per class;* _____ *minutes maximum per night; take a break every* _____ *minutes* ☐ Will attempt homework, but will stop if symptoms occur ☐ Extra tutoring/assistance requested ☐ May begin make-up of essential work	
Testing	☐ No Testing ☐ Additional time for testing/ untimed testing ☐ Alternative Testing methods: oral delivery of questions, oral response or scribe ☐ No more than one test a day ☐ No Standardized Testing	
Educational Plan	☐ Student is in need of a formal site-based academic support plan	
Physical Activity	☐ No physical exertion/athletics/gym/recess ☐ Untimed walking in PE class/recess only ☐ May begin graduated return to play protocol; see CIF Return to Play (RTP) protocol (cifstate.org)	