Revised 10/27/2020

Return to Learn: Academic Accommodation Plan Following a Concussion

(To be completed by medical provider)

<u>This form should be brought to the school nurse immediately upon return to school to initiate the health alert process.</u>

Student's name: _____ Date of birth: _____

The above student has been diagnosed with a concussion (also known as a mild traumatic brain injury). Following a concussion individuals need both cognitive and physical rest to allow for the best and quickest recovery. Therefor it is important to limit activities that require a lot of thinking or concentration, as this can make the symptoms worse.

The student is able to return to school (date) _____ with the following recommended supports:

	No supports necessary. Student has been released to return to full academic and athletic/physical fitness activities.

_____ To promote cognitive rest: To expire: _____ (Date)

	Allow for shortened school days. Recommended _____ hours per day until re-evaluated. (Alternating days of morning/afternoon classes suggested if ≤4 hours/day recommended)
	Allow for shortened classes (i.e. rest breaks during class) Maximum class length _____ minutes.
	Allow extra time to complete coursework/assignments.
	No classroom or standardized testing at this time, as this does not reflect the student's true abilities.
	Limited classroom testing allowed. No more than _____ questions and/or _____ total time.
	Student is able to take quizzes or tests that are written but not bubble sheets.
	Student is able to take tests but should be allowed extra time to complete.
	Lessen screen time (computer, videos, SmartBoard) to a maximum of _____ minutes per class AND no more than _____ continuous minutes (with 5-10 minute break in between).
	Print class notes and online assignments (14 Font recommended)
	Lessen homework by _____% per class; or to a maximum of _____ total minutes nightly for all classes, no more than _____ continuous.

To address sensitivity to noise and light: To expire: _____ (Date)

	Provide alternative setting during band or music class (outside of band room or music classroom).
	Provide alternative setting during PE and recess to avoid noise exposure and risk of further injury (out of the gym).
	Allow early class release for class transitions to reduce exposure to hallway noise.
	Provide alternative location to eat lunch outside the cafeteria.
	Allow the use of earplugs when in a noisy environment during the school day.
	Allow student to wear sunglasses or a hat with a bill worn forward to reduce light exposure.

To reduce risk of further injury:

- Students participating on the school athletic teams will be working with their athletic trainers and medical provider on their Gradual Return to Play and completion of the Gfellar-Waller form.
- No student should return to full physical activity (PE, recess, etc) if ANY symptoms are present
- For non-athletes in elementary, middle or high school:

_____ No PE/Recess/Participation in any classes or events involving physical activity or on sports teams until re-evaluated.

_____ Patient has completed a return to play progression and is able to participate in PE/Recess/and any other classes or events involving physical activity as long as symptom free.

These recommendations are based on today's evaluation. Date: _____

Student is scheduled to return to this office. (Date or in approximate number of days/weeks) _____

Referral has been made to: ☐ Sports Medicine ☐ Neurology ☐ Psychologist ☐ Psychiatrist ☐ Other _____

Signature of medical provider: _____ MD DO NP PA-C

Name of provider (print): _____ Office phone:_____

To be completed by parent/guardian:

I agree with the above recommendations and would like them to be implemented: Yes ☐ No ☐

The best number to reach me during the day to discuss my child's plan for school is _____.

RELEASE OF INFORMATION: I give permission for the school nurse/school personnel to exchange information regarding my child's care following the concussion with the provider/office listed above. Yes ☐ No ☐

Parent signature: _____ Date: _____

Form was received and reviewed by the school nurse: (Date & Signature) _____
Health alert process was initiated by the school nurse: (Date)_____
Copy Given to: _____ HR Teacher _____PE Teacher _____ Counselor _____ Principal (Date) _____