Return to Learn:
Concussion Medical Care Plan

Student Name: _____ DOB: _____ Date: _____

Grade/Teacher: _____ Date of Injury: _____ Will Return to Medial Office on: _____

TO BE COMPLETED BY HEALTHCARE PROVIDER

Today the following symptoms are present:

☐ No symptoms observed or reported

Physical		Thinking	Emotional	Sleep
☐ Headaches	☐ Sensitivity to light	☐ Feeling mentally foggy	☐ Irritability	☐ Drowsiness
☐ Nausea	☐ Sensitivity to noise	☐ Problems concentrating	☐ Sadness	☐ Sleeping more than usual
☐ Fatigue	☐ Numbness/Tingling	☐ Problems remembering	☐ Feeling more emotional	☐ Sleeping less than usual
☐ Visual problems	☐ Vomiting	☐ Feeling slowed down	☐ Nervousness	☐ Trouble falling asleep
☐ Balance problems	☐ Dizziness			

Return to Learn: *(check all that apply)*

☐ No return to school. Return on (date) _____

☐ No school until re-evaluated on (date)_____

☐ Return to school with no academic restrictions.

☐ Return to school on (date) _____ with the following academic supports:

- ☐ Shortened day. Recommend _____ hours per day until _____.
- ☐ Shortened classes (i.e. rest breaks during classes). Maximum class length of _____ minutes.
- ☐ Allow extra time to complete coursework, assignments and tests.
- ☐ Lessen homework load by _____%. Maximum length of nightly homework _____ minutes.
- ☐ No significant classroom or standardized testing at this time, as this does not reflect the student's true abilities.
- ☐ May resume regular test taking.
- ☐ Limit classroom testing as follows:
  - ☐ No more than _____ questions and/or _____ total time.
  - ☐ Student is able to take quizzes or tests but no bubble sheets.
  - ☐ Student is able to take tests but should be allowed extra time to complete.
- ☐ Provide printed materials/notes/assignments.
- ☐ Check for the return of symptoms when doing activities that require a lot of attention and/or concentration. Notify school nurse.
- ☐ Take rest breaks during the day as needed.
- ☐ Provide alternate setting for band/music, PE, and lunch to avoid noise exposure.
- ☐ No computer/screen time.
- ☐ Limit computer/screen time. Maximum of _____ minutes per class.
- ☐ Allow early class release for class transitions to reduce exposure to hallway noise.
- ☐ Allow the use of ear plugs (no music) 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.
- ☐ Allow school Concussion Management Team (CMT) to gradually modify academic accommodations if student remains symptom free.
- ☐ Other recommendations:_____

Return to Play (Physical activity):

The above student should adhere to the following recommendations regarding physical activity (recess, PE, Athletic participation):

- ☑ No student will return to play if symptoms are still occurring at rest, with cognitive stress, or with physical activity.
- ☐ **No physical activity** until further notice.
- ☐ Aerobic, non-contact physical activity only (walk, jog, run).
- ☐ Is medically cleared to participate in full physical activity.
- ☐ May **gradually** return to school athletic teams under appropriate supervision (i.e. coach, athletic trainer) per NCHSAA Concussion Return to Play Protocol.

Signature of Healthcare Provider: _____ Date: _____

Print name: _____ Providers Phone #: _____

- I agree with the above recommendations.
- I give permission for the school nurse/school personnel to exchange information regarding my child's care following concussion with the provider/office listed above.

Signature of Parent: _____ Date:_____ Phone number: _____

Reviewed by School Nurse/Concussion Management Team _____ Date:_____

Signature