Return to School After Concussion or Head Injury

Student Name _____ Date of Birth _____ Date of Exam _____

To whom it may Concern:

Injury Status (check all that apply)

- ❑ This student was evaluated and did not have a concussion injury. There are no limitations on school and physical activity.
- ❑ This student has been diagnosed by a health care professional who has been trained in the management of concussions, with a concussion and is under our care.
- ❑ Medical follow-up is scheduled for: _____ (date).

Academic Activity Status (check all that apply)

- ❑ This student is no longer experiencing any signs or symptoms of concussion and may be released to full academic participation.
- ❑ This student is not to return to school.
- ❑ This student may begin a return to school based on successful progression through a Return to Learn protocol.

Comments: _____

Physical Activity Status (check all that apply)

- ❑ This student is cleared for full, unrestricted athletic participation.
- ❑ This student is not to participate in physical activity of any kind.
- ❑ This student is not to participate in recess, physical education class, or athletics, or other physical activities except for untimed, voluntary walking.
- ❑ This student may begin a monitored, graduated return to play progression, until _____ (date).
- ❑ Other: _____

Additional special instructions _____

Stamp physician name/address below

Signature of Physician _____ Date _____

Name of Physician (please print) _____ License Number _____ Office telephone _____

Parent or Legal Guardian Acknowledgement

I hereby give consent for a school nurse (or designee) to communicate with my child's Health Care Provider and to counsel school personnel as needed with regard to my child's health. I agree to, and do hereby hold the District and its employees harmless for any and all claims, demands, causes of action, liability or loss of any sort, because of or arising out of acts or omissions with respect to concussion signs and symptoms. I agree to comply with district rules related to concussion return to play and return to learn.

Signature of Parent or Legal Guardian _____ Date _____ Home/Mobile Telephone _____ Work Telephone _____

Name of Parent or Legal Guardian (please print) _____