CHAPPAQUA CENTRAL SCHOOL DISTRICT: RECOMMENDATIONS FOLLOWING CONCUSSION

Student Name: _________________________________ DOB: _______________ Date of Evaluation: ____________

This patient has been diagnosed with a concussion and is currently under our care. The following are suggestions for adjustments requested to support the student's recovery.

Interscholastic Athletics: No student shall resume athletic activity until he/she/they has been symptom-free for at least 24 hours. The student can begin Return-to-Play (RTP) protocols AFTER being asymptomatic of any concussion symptoms for that duration AND after being evaluated by a licensed physician/neurologist and has received a written/signed authorization from.

The patient will be reassessed for revision of these recommendations in ___________ weeks.

Attendance/Breaks

- ☐ Full school days, as tolerated by the student
- ☐ No school for ____________ school day(s)
- ☐ Attendance at school _____ days per week
- ☐ Partial days, as tolerated by the student
- ☐ Allowed to go to the nurse's office if sx increase
- ☐ Allowed to go home if symptoms do not subside
- ☐ Allowed breaks during school day, as needed
- ☐ Other ______________________________________

Visual Stimulus/Audible Stimulus

- ☐ Allowed student to wear sunglasses/hat in school
- ☐ Excused from music or shop classes
- ☐ Pre-printed notes for class material/note taker
- ☐ Limited computer, TV screen, bright screen use
- ☐ Reduced brightness on monitors/screens
- ☐ Allowed lunch in a quiet place with a friend
- ☐ Allowed to wear earplugs, as needed
- ☐ Allowed class transitions before bell
- ☐ ____
  ____

Workload/Multi-Tasking/Testing

- ☐ Reduced overall amount of make-up work, classwork and homework
- ☐ Additional time to complete tests
- ☐ Pro-rated workload, when possible
- ☐ No more than one test per day
- ☐ Reduced amount of daily homework given
- ☐ Allowed for scribe, oral response and oral delivery of questions, if available
- ☐ ____________________________________

Physical Exertion/Activity

- ☐ No physical exertion/athletics/gym/recess
- ☐ Walking in gym class only
- ☐ Begin return to play protocol as outlined by the "Return to Activity" form
- ☐ ____

Current Symptoms List (the student is noting these today)

- ☐ Balance Problems
- ☐ Difficulty Concentrating
- ☐ Dizziness
- ☐ Fatigue
- ☐ Headache
- ☐ Irritability
- ☐ Memory Issues
- ☐ Nausea
- ☐ Sensitivity to Light
- ☐ Sensitivity to Noise
- ☐ Sensitivity to Sound
- ☐ Visual Issues

Provider Name ____ Provider Role: ☐ MD/DO ☐ PA ☐ NP

Office Phone ______________________________________ Office Fax ____________________________

Signature ____ Date ______________

Parent Permission to Share Information

I give permission for my health care provider(s) above to share information/communicate with the school nurse and/or medical director or ____ at my child's school.

Parent/Guardian Signature____ Date ______________.