

Physician Letter to School

Patient/Student Name: _____ DOB: _____ Date of Injury: _____

INJURY STATUS	INJURY STATUS/Date of Diagnosis: _____
____ This student was evaluated by an MD/DO and is determined to NOT have a concussion and has medical clearance for unrestricted athletic participation.	____ This student was evaluated by an MD/DO, is diagnosed with a concussion, and is under our care. Medical follow-up evaluation is scheduled for: _____
ACADEMIC STATUS	ACADEMIC STATUS (mark all that apply)
____ This student is not/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 until _____. ____ This student is to return to school for a partial day, as tolerated. ____ This student may begin to return to school based on successful progression through the concussion RTL Protocol. Specific restrictions must be checked off on the back of this form.
PHYSICAL ACTIVITY STATUS	PHYSICAL ACTIVITY STATUS (mark all that apply)
____ This non-athlete student may return to unrestricted physical activity after a period of 7 days with no signs or symptoms of a concussion. ____ This non-athlete student has completed 7 days of rest with no signs or symptoms of a concussion and may return to unrestricted physical activity.	____ This student is not to participate in physical activity of any kind. (PE/Dance) ____ This student may begin a graduated return to sport-based activity based on the successful progression through the concussion RTP Protocol.

ACADEMIC SUPPORT CONTACT
_____ School Counselor
PHYSICAL ACTIVITY SUPPORT CONTACT
Athletic Trainer (athlete) Rachel Pantaleo (TRITON), Athena Killelea (HIGHLAND), Dominic Acchitelli (TIMBER CREEK) School Nurse (non-athlete) Christa Moore (TRITON), Jeanine Trommater/Jackie Keehn (HIGHLAND), Monica Coslove (TIMBER CREEK)

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

Physician Stamp & Contact Information:

***If APN/Physical Therapist are treating the student, we still require the MD/DO to sign off.**
Please note: Clearance from a health care provider is not required to return to cognitive activity.
The Concussion Team will monitor and adjust the academic restrictions as necessary as the student progresses.

Academic Restrictions - Please allow for the following accommodations:

- ☐ Excuse from school until at least _____. The student may return earlier if they are having fewer/no (circle one) symptoms at home.
- ☐ Shortened school day when the student returns. Recommend ____ hours per day until _____. The student may extend his/her day as tolerated.
- ☐ Allow student to go to the nurse's office as needed and to go home if symptoms do not subside after _____ scheduled _____ minute breaks.
- ☐ Preferential seating in class to minimize distractions.
- ☐ Limit screen time to _____ hours per day.
- ☐ No written tests (classroom or standardized) or written quizzes. Oral assessments are permitted.
- ☐ Allow extra time to complete tests, quizzes and assignments.
- ☐ Chunking Material on tests or quizzes - allowing student to take over amount of time.
- ☐ Limit homework and in class assignments to essential material only.
- ☐ Provide pre-printed class notes and allow participation in class by listening with no note-taking.
- ☐ Allow student to avoid loud and crowded places (hallways, auditoriums, lunch, music class, etc.) as needed.
- ☐ Allow student to leave early to move from class to class in an empty hallway.
- ☐ Request a meeting for a 504 plan or with School Management Team to discuss the plan when it appears student may not be able to return to full academic responsibilities after 8 weeks.
- ☐ Exclude student from: Vocal Music, Choir, Band, ROTC (pt portion).
- ☐ Exclude from Woodshop class (Triton only).
- ☐ Return to full academic responsibilities.
- ☐ **Other:**

A follow-up appointment is recommended in _____ weeks to update the status of the student's academic restrictions.

AUTHORIZATION TO RELEASE INFORMATION

I, _____, the parent of _____, hereby give permission for the Black Horse Pike Regional School District personnel and the medical professional noted on this form to share information with each other related to my child's medical condition and his/her school attendance, academic performance, and participation in school activities, including athletics, if applicable.

Black Horse Pike Regional School District Personnel may include:

- Child's School Counselor
- Child's student assistance counselor or school nurse
- If my child participates in school sports, the athletic director and the athletic trainer

Medical statements being provided to school personnel should be sent to the school nurse:

Triton High School, Christa Moore, RN: cmoore@bhprsd.org Fax # 856-939-4724

Timber Creek High School, Monica Coslove, RN; mcoslove@bhprsd.org Fax # 856-741-1439

Highland High School, Jeanine Trommater, RN: jtrommater@bhprsd.org or Jackie Keehn, RN: jkeehn@bhprsd.org Fax # 856-842-1512

Name of Medical Professional: _____

Address: _____

Email address: _____

Phone Number: _____ Fax Number: _____

This authorization must be signed and dated for validity and may be revoked at any time except to the extent that action has already occurred prior to the revocation. I release the disclosing party from any liability that may be incurred by giving this information to the above-named person or agency.

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

This release expires one year from the date of signing unless otherwise indicated.

Please return this form to the Counseling Office at the student's school.