



"Return to Learn" and "Return to Play"

Updated: May 2024

Student Name:

Grade:

Diagnosis:

Date of Concussion:

Medical History:

Medication:

Physician Note and Signature:

Emergency Contact
Information:

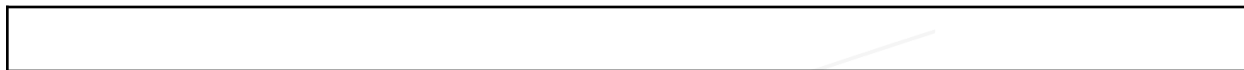
**Community Consolidated
School District 181**

Address: 115 W 55th St, Clarendon Hills, IL
60514

Hours: Weekdays 8AM-4PM

Phone: (630) 861-4900

Fax: (630) 887-1079



D181 Concussion Return to Learn and Return to Play Protocol
Concussion Surveillance

Any student suspected of having sustained a concussion during the school day, on school grounds, when the school nurse is on duty, will be seen by the nurse and evaluated. If no nurse is available, after school hours or on a field trip, parents will be contacted, and in an emergency, 911 will be called in an emergency.

The student may also be referred to the nurse if a concussion or concussion symptoms are suspected from an injury sustained outside school hours. The nurse will assess the student and contact the parent(s) to follow up. If an emergency is suspected, the nurse will contact 911.

Any student with a diagnosed concussion per a licensed healthcare professional (MD, DO, ATC, APN, PA) will not be able to participate in PE and recess until documented medical clearance is provided by the treating provider.

All interscholastic athletic coaches are required to complete an online concussion training, provided specifically to coaches by the CDC/NFHS: <https://n.fhslearn.com/courses/61064/concussion-in-sports>

Return to Learn & Return to Play Protocols:

Any student with a diagnosed concussion per a licensed healthcare professional (MD, DO, ATC, APN, PA) will be enrolled in d181's Return to Learn and Return to Play protocol (detailed on the next page)

The student's parent or guardian will be given an assessment tool to monitor the student's symptoms. This evaluation must be completed daily by a parent or guardian and given to the nurse daily upon arrival at school. This assessment will be used to help determine students' recovery stage and level of student participation in school.

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Middle School Interscholastic Athletes Only :

Any middle school student participating in interscholastic sports (basketball, cross country, cheerleading, volleyball, track & field) will be required to submit the following before participating in any try-outs and practices:

- 1 . Current sports physical that was completed within 12 months through the duration of the sport (the 6th-grade state of Illinois required physical meets this requirement). Please submit the updated physical to the building nurse.
2. Parent(s) and student-athletes must review/sign the annual Agreement to Participate Form and submit it to their coach.
3. Any interscholastic athlete with a diagnosed concussion per a licensed healthcare professional (MD, DO, ATC, APN, PA) will not be able to participate in PE or interscholastic sports until
 - I. The student has completed the D181 Return to Play and Return to Learn protocol.
 - II. The student's parent(s) sign the return to play post-concussion form.

District 181 Post-Concussion Consent Form (RTP/RTL)

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Community Consolidated

School District 181

Date: _____

Student's Name: _____ Grade: _____

By signing below, I acknowledge the following:

1. I have been informed concerning and consent to your students participating in returning to play in accordance with the return-to-play and return-to-learn protocols established by Illinois State Law.
2. I understand the risks associated with my student returning to play and returning to learn and will comply with any ongoing requirements in the return-to-play and the return-to-learn protocols established by Illinois State Law.
3. I consent to the disclosure to appropriate persons, consistent with the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), of the treating physicians or athletic trainer's written statement and if any, the return-to-play and return-to-learn recommendations of the treating physician or the athletic trainers the case may be.
4. Take the attached physician's form and copy of the return-to-play and return-to-learn protocols to the student's treating physician to review and sign as to the treatment plan to follow.
5. Complete the Parental Daily Evaluation form and return it to the nurse's office daily.

Student's Signature: _____

Parent/Guardian's signature: _____

Student Name:

DOB:

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Concussion Recovery Stages:

Recovery Stage 1	Recovery Stage 2	Recovery Stage 3	Recovery Stage 4	Recovery Stage 5
Complete physical and cognitive rest until medical clearance No School Attendance Strict limits on technology Rest	Return to school with Academic Accommodations and No Physical Activity** Continue limits on technology usage Avoids audible stimulus (no lunchroom, band, chorus, etc.)	Continue Academic Accommodations and No Physical Activities** Attend school full-time if possible Increase workload gradually (testing, homework, etc.) Monitor Symptoms Rest at home	Full Recovery to Academics and Modified Physical Activity** Attend School Full Time With medical clearance, incorporate light activities (NO head impact or contact sports) Monitor Symptoms Rest at Home	Full Recovery to Physical Activities** Must be reevaluated and cleared in writing by the treating physician to return to FULL participation in sports and/or PE
Symptom-Free for 24 hours* Yes: Begin stage 2 No: Continue resting	Symptom-Free for 24 hours* Yes: Begin stage 3 No: Return to Stage 1 and Rest until symptom-free	Symptom-Free for 24 hours* Yes: Begin stage 4 No: Return to Stage 2 until symptom-free	Symptom-Free for 24 hours* Yes: Begin stage 5 No: Return to Stage 3 until symptom-free	Symptom-Free for 24 hours* Yes: Completed Protocol No: Return to stage 4 until the letter received

• unless physician orders indicate otherwise, physical activity includes PE, recess, intramural & interscholastic sports.
Physician Completes:

- I have reviewed and am in agreement with the D 181 Concussion Return to Learn and Return to Play Protocol.
- Yes
- No (If No, please include a separate letter specifying recommendations) Comments:

Physician Name: _____

Signature _____ Date: _____

Daily Evaluation Assessment
(To be completed by a parent and sent to the nurse daily)



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Student's Name: _____

Parent Signature: _____

Week #: _____

Date: : _____

Symptom Date Completed	Day 1	Day 2	Day 3	Day 4	Day 5
Headache					
Nausea					
Balance concerns					
Dizziness					
Visual concerns					
Light sensitivity					
Noise sensitivity					
Memory concerns					
Difficulty concentrating					
Numbness or tingling					
Emotional concerns					
irritability					
fatigue					
Sleeping more than usual					
Symptoms during physical activity					
Symptoms occurring during cognitive activity					

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