

**HCS Student Health Services****Concussion Clearance/Head Injury Form and Care Plan**

Healthcare Provider to complete/sign. Parent/Guardian to sign. Return to School Nurse.

April 2019

Student \_\_\_\_\_ DOB \_\_\_\_\_ School \_\_\_\_\_  
Date of Injury \_\_\_\_\_ Is student an athlete? \_\_\_ Yes \_\_\_ No If yes, list sport(s) \_\_\_\_\_  
Where did injury occur? \_\_\_ School: \_\_\_ PE \_\_\_ Recess/Playground \_\_\_ Other: \_\_\_\_\_  
Athletic Sport, list \_\_\_\_\_ Home \_\_\_\_\_ Other, list: \_\_\_\_\_  
Briefly describe what happened: \_\_\_\_\_

**Physical**

\_\_\_ Headaches  
\_\_\_ Nausea  
\_\_\_ Fatigue  
\_\_\_ Visual problems  
\_\_\_ Balance problems  
\_\_\_ Sensitivity to light  
\_\_\_ Sensitivity to noise  
\_\_\_ Numbness/Tingling  
\_\_\_ Vomiting  
\_\_\_ Dizziness

**Thinking**

\_\_\_ Feeling mentally foggy  
\_\_\_ Problems concentrating  
\_\_\_ Problems remembering  
\_\_\_ feeling more slowed down

**Emotional**

\_\_\_ irritability  
\_\_\_ Sadness  
\_\_\_ Nervousness  
\_\_\_ Excessive or Abnormal

**Sleep**

\_\_\_ Drowsiness  
\_\_\_ Sleeping more than usual  
\_\_\_ Sleeping less than usual  
\_\_\_ Trouble falling asleep

**Additional comments/details about injury and/or symptoms:** \_\_\_\_\_  
Completed by: \_\_\_\_\_ School Nurse \_\_\_ 1 st Responder \_\_\_ Coach \_\_\_ Other Staff \_\_\_ Parent Date: \_\_\_\_\_

**Medical recommendations - Healthcare Provider to Complete/Sign****Return to School**

\_\_\_ Out of school until follow-up visit on \_\_\_\_\_ (date).  
\_\_\_ May return to school \_\_\_\_\_ with \_\_\_\_\_ without academic accommodations on \_\_\_\_\_ (date).

**Academic Accommodations** (Check all that apply.):

\_\_\_ Shortened day. Recommended \_\_\_\_\_ hours per day until \_\_\_\_\_ (date).  
\_\_\_ Shortened classes (i.e. rest breaks during classes). Maximum class length \_\_\_\_\_ minutes.  
\_\_\_ Allow extra time to complete coursework/assignments and tests.  
\_\_\_ Lessen homework load to maximum nightly \_\_\_\_\_ minutes, no more than \_\_\_\_\_ continuous minutes.  
\_\_\_ Lessen computer time to maximum \_\_\_\_\_ minutes, no more than \_\_\_\_\_ continuous minutes.  
\_\_\_ No significant classroom or standardized testing at this time, as this does not reflect the student's true abilities.  
\_\_\_ Check for the return of symptoms (above) when doing activities that require a lot of attention or concentration.  
\_\_\_ Take rest breaks during the day as needed.  
\_\_\_ Review academic accommodations on \_\_\_\_\_ (date).

**Physical Education/Recess**

\_\_\_ Do NOT return to PE class/recess at this time \_\_\_ May return to PE class/recess  
\_\_\_ Can return to PE class/recess after completion of return-to-play progression – Complete/sign list on back page.

**Sports**

\_\_\_ Do not return to sports practice or competition at this time. \_\_\_ N/A.  
\_\_\_ May start return to practice/play following gradual progression steps (back page) under the supervision of appropriate health care provider.  
\_\_\_ May be advanced back to competition after phone conversation with attending physician.  
\_\_\_ Must return to medical provider for final clearance to return to competition.  
\_\_\_ Has completed a gradual RTP progression (back page) w/o any recurrence of symptoms and is cleared for full participation, as of \_\_\_\_\_ (date).

**Follow-up/Referrals**

\_\_\_ Return to this office. Date/Time: \_\_\_\_\_ Refer for neuropsychological testing.  
\_\_\_ Refer to: \_\_\_ Neurosurgery \_\_\_ Neurology \_\_\_ Sports Medicine \_\_\_ Psychiatrist (Physical Medicine/Rehabilitation)  
\_\_\_ Psychiatrist \_\_\_ Other, list: \_\_\_\_\_

**Healthcare Provider Name (Print):** \_\_\_\_\_ **Signature:** \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_ Examination Date: \_\_\_\_\_

**Parent/Guardian to Complete and Return to School Nurse** School Nurse to file in IHP, copies to appropriate staff & EAP notebook (initial)

I have received and will comply with the concussion and head injury sign/symptoms information, guidelines for care, and above noted return to learning/play recommendations. I authorize permission for school personnel to implement this plan of care.

**Parent/Guardian Signature:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **Date** \_\_\_\_\_

**Returning to Daily Activities****Parent/Guardian & Student Instructions/Guidelines**

1. Get lots of rest. Be sure to get enough sleep at night- no late nights. Keep the same bedtime weekdays and weekends.
2. Take daytime naps or rest breaks when you feel tired or fatigued.
  - Limit physical activity as well as activities that require a lot of thinking or concentration. These activities can make symptoms worse.
  - Physical activity includes PE, sports practices, weight-training, running, exercising, heavy lifting, etc.
3. Thinking and concentration activities (e.g., homework, classwork load, job-related activity).
4. Drink lots of fluids and eat carbohydrates or protein to maintain appropriate blood sugar levels.
5. As symptoms decrease, you may begin to gradually return to your daily activities. If symptoms worsen or return, lessen your activities, then try again to increase your activities gradually.
6. During recovery, it is normal to feel frustrated and sad when you do not feel right and you can't be as active as usual.
7. Repeated evaluation of your symptoms is recommended to help guide recovery.

**Returning to School**

1. If student is still having symptoms of concussion he/she may need extra help to perform school-related activities. As your (or your child's) symptoms decrease during recovery, the extra help or supports can be removed gradually.
2. Inform the teacher(s), school nurse, school psychologist or counselor, and administrator(s) about your (or your child's) injury and symptoms. School personnel should be instructed to watch for:
  - Increased problems paying attention or concentrating.
  - Increased problems remembering or learning new information.
  - Longer time needed to complete tasks or assignments
  - Greater irritability, less able to cope with stress.
  - Symptoms worsen (e.g., headache, tiredness) when doing schoolwork.
3. Follow the recommendations on front page until student has fully recovered.

**Returning to Sports**

1. You should NEVER return to play if you still have ANY symptoms – (Be sure that you do not have any symptoms at rest and while doing any physical activity and/or activities that require a lot of thinking or concentration.)
2. Be sure that the PE teacher, coach, and/or athletic trainer are aware of your injury and symptoms.
3. It is normal to feel frustrated, sad, and even angry because you cannot return to sports right away. With any injury, a full recovery will reduce the chances of getting hurt again. It is better to miss one or two games than the whole season.
4. Gradual return to sports practices under the supervision of an appropriate health care provider.
  - Return to play should occur in gradual steps beginning with aerobic exercise only to increase your heart rate (e.g., stationary cycle); moving to increasing your heart rate with movement (e.g., running); then adding controlled contact if appropriate; and finally return to sports competition.
  - Pay careful attention to your symptoms and your thinking and concentration skills at each stage of activity. Move to the next level of activity only if you do not experience any symptoms at the each level. If your symptoms return, stop these activities and let your health care professional know. Once you have not experienced symptoms for a minimum of 24 hours and you receive permission from your health care professional, you should start again at the previous step of the return to play plan.

**Gradual Return to Play Plan**

1. No physical activity.
2. Low levels of physical activity (i.e.). This includes walking, light jogging, light stationary biking, and light weightlifting (lower weight, higher reps, no bench, and no squats).
3. Moderate levels of physical activity with body/head movement. This includes moderate jogging, brief running, moderate intensity stationary biking, moderate-intensity weightlifting (reduced time and/or reduced weight from your typical routine).
4. Heavy non-contact physical activity. This includes sprinting/running, high-intensity stationary biking, and regular weightlifting routine, non-contact sport-specific drills (in 3 planes of movement).
5. Full contact in controlled practice.
6. Full contact in game play.

*Neuropsychological testing can provide valuable information to assist physicians with treatment planning, such as return to play decisions.*