CAMP HILL SCHOOL DISTRICT
418 South 24th Street Camp Hill, PA 17011 717-901-2400 www.camphillsd.k12.pa.us

CAMP HILL CONCUSSION MANAGEMENT TEAM
PHYSICIAN ACCOMODATION FORM

Student/Athlete Name:_____ Date of Birth:_____
Date of Injury:_____ Date of Initial Exam:_____
Sport:_____ School:_____
Concussion Monitor Contact:_____
Concussion Monitor Number:_____

- ☐ After reviewing the attached medical facts, it is my opinion that the student **DID NOT** sustain a concussion on the above date noted and is released to play in the above sport.

- ☐ The above named student **HAS SUSTAINED A CONCUSSION** on the date of injury noted and should not return to participation in athletics until school district return to play criteria have been met. The student's progress through the stages will be monitored by a Certified Athletic Trainer and/or Nurse.

Until the above name student has fully recovered, the following academic accommodations are recommended: *(check all that apply)*

___ No return to school. Return on (date)
___ Shortened day. Recommend ____ hours per day until (date)
___ Shortened classes (i.e. rest breaks during classes. Maximum class length ____minutes
___ No PE class until further notice
___ Restricted PE class-Should not participate in activity that would put student at risk for head injury
___ Allow extra time to complete coursework, assignments, and tests
___ Modify homework assignments
___ Temporarily excuse student from class that may be over stimulating due to light/noise
___ No note taking. Provide student with teacher generated notes
___ No significant classroom or standardized testing at this time
___ Take rest breaks during the day as needed
___ Other (please specify)

By signing below, I hereby certify that I am **familiar with current concussion management and I can certify that all aspects of evaluation, treatment, and risk of that injury have been thoroughly covered with the student.**

Physician Name (printed)_____

Physician Signature (Must be MD or DO)_____

Physicians Address:_____

Physicians Phone Number:_____

FORM MUST BE SIGNED BY MD OR DO. NO OTHER SIGNATURES WILL BE ACCEPTED.