Fayette County School Health Services

CONCUSSION HEALTH CARE PLAN

Please bring or mail this health care plan to the school or send to the secure FAX at 770-719-2639.

Student: ______________________________ **Birth Date:** __________ **School Year:** _________

School: ______________________________ **Homeroom Teacher:** ____________________ **Grade/Team:** _________

Date Concussion occurred: ____________________ Date Child May Return to School: _____________________

☐ Activity restrictions (*review physical exertion below*) ☐ Cleared for full activity

☐ Please allow the following recommendations from date _________________ through date ___________________

Attendance

☐ No school for ______________ school day(s)
☐ No school until symptom free or significant decrease in symptoms
☐ Part time attendance for _________ days as tolerated
☐ Full school days as tolerated
☐ Other ____

Visual/ Light Sensitivity

☐ Allow to wear sunglasses in school
☐ Allow access to darkened area to rest for _________ minutes
☐ Contact parent to go home if symptoms do not subside
☐ Other ____

Auditory Sensitivity

☐ Allow to leave class 5 min early to avoid noisy hallways
☐ Lunch in a quiet place
☐ Allow access to quiet area to rest for __________ minutes
☐ Contact parent to go home if symptoms do not subside
☐ Other ____

Physical Exertion

☐ No physical exertion/athletics/gym/after school activities
☐ No recess
☐ Light aerobic activities only
☐ Non-contact/non-collision activities only
☐ Begin return to play protocol prior to returning to gym, athletics, after school activities
☐ Allow return to after school activities as observer only
☐ Allow return to after school activities as participant
☐ No restrictions for physical exertion/athletics/gym/after school activities

Breaks

☐ Allow access to nurse's office if symptoms persist
☐ Allow access to increased water intake
☐ Allow access to restroom if increased water intake
☐ Other ____

Additional Recommendations:

Current Symptom List

☐ Headache	☐ Difficulty remembering	☐ Feeling more emotional	☐ Sleeping more than usual
☐ Difficulty concentrating	☐ Sensitivity to noise	☐ Sleeping less than usual	☐ Fatigue
☐ Sensitivity to light	☐ Drowsiness	☐ Nausea	☐ Balance problems
☐ Trouble falling asleep	☐ Dizziness	☐ Feeling mentally foggy	
☐ Visual problems	☐ Feeling slowed down	☐ Irritability	

PAIN MANAGEMENT:

Medication Name	*Dosage (amount)/Time*	*When To Use*	*Given at School*
			☐ YES ☐ NO
			☐ YES ☐ NO

►***Physician's Signature***◄ ____ ***Date:*** _______________

PRINT Physicians Name: ____ **Phone #:** _______________

I, this child's parent/guardian, hereby authorize the named Healthcare Provider who has attended to my child, to furnish to the School Health Services Coordinator and/or School Clinic Staff any medical information and/or copies of records pertaining to my child's chronic health condition and for this information to be shared with pertinent school staff at my child's school. I understand that as of April 14, 2003, under the Health Insurance Portability and Accountability Act ("HIPAA") disclosure of certain medical information is limited. However, I expressly authorize disclosure of information so that my child's medical needs may be served while in attendance in the Fayette County Schools. This authorization expires as of the last day of the school year.

►**Parent/Guardian's Signature**◄ ____ **Date:** ____________

Implemented: March 2014