



Mount Greylock Regional School
1781 Cold Spring Road
Williamstown, MA 01267
Tel: (413) 458-9582 Fax: (413) 458-9581



Dear Physician,

This patient is currently a student at Mount Greylock Regional School and is in need of medical attention or clearance for a head injury. In accordance with Massachusetts Law 105CMR 201.000, Mount Greylock has developed a policy that every student with a head injury or possible concussion must be evaluated and cleared by a physician before they are able to return to physical education and/or athletic participation.

The attached forms have been reviewed and revised. To facilitate the student's return to activities and to help the school ensure all needed accommodations are met, please complete the attached *Academic Recommendation Form* as soon as possible. Additionally, when the student is medically cleared to return to full physical participation, please complete the *Post Sports-Related Head Injury Medical Clearance and Authorization Form*. The first form stipulates what restrictions, if any should be placed upon the student's academic and physical activities. If you are placing restrictions on either activity, please provide a date by which the student will be re-evaluated. The second form states that the student is symptom free, has completed the state mandated Return-to-Play protocol, and is able to safely participate in physical education and athletics at Mount Greylock. **If there is no evidence of completion of the return to play protocol, students will be required to begin that upon return.** **The student will be out for a minimum of five days once the protocol has begun.** Students not enrolled in Physical Education or participating on an athletic team will be required to complete this protocol with the physician.

We appreciate your help with these forms so that we may comply with the Massachusetts Law and ensure our students are safe. Please feel free to contact me or the school nurse at the school if you have any questions. Thank you for your cooperation and willingness to help our students.

Sincerely,

Lindsey von Holtz
Director of Athletics and Co-Curricular Activities
Mount Greylock Regional School
1781 Cold Spring Road, Williamstown, MA 01267
(413) 458 - 9582 x103

ACADEMIC RECOMMENDATION FORM
PLEASE SEND THIS FORM BACK WITH STUDENT IMMEDIATELY

Patient Name: _____ Date of Birth: _____
 Date of Evaluation: _____ Referred by: _____
 Duration of Recommendations: 1 week 2 weeks 4 weeks Until further notice

The patient will be reassessed for revision of these recommendations in _____ weeks.

This patient has been diagnosed with a concussion (a brain injury) and is currently under our care. Flexibility and additional supports are needed during recovery. The following are suggestions for academic adjustments to be individualized for the student as deemed appropriate in the school setting.

Attendance

- ___ No school for ___ school day(s)
- ___ Attendance at school ___ days per week
- ___ Full school days as tolerated by student
- ___ Partial days as tolerated by the student

Visual Stimulus

- ___ Allow student to wear sunglasses/hat
- ___ Pre-printed notes (or note taker) for class
- ___ Limited computer/bright screen use
- ___ Reduce brightness on monitors/screens
- ___ Change classroom seating as necessary

Audible Stimulus

- ___ Lunch in a quiet place with a friend
- ___ Avoid music or shop classes
- ___ Allow to wear earplugs as needed
- ___ Allow class transitions before bell

Breaks

- ___ Allow the student to go to the nurse's office if symptoms increase
- ___ Allow student to go home if symptoms do not subside
- ___ Allow breaks during the school day as deemed necessary by school nurse

Workload/Multi-Tasking

- ___ Reduce overall amount of make-up work, classwork and homework (*Approx %: ___*)
- ___ Reduce amount of work given each night to approximately ___ minutes per class.
- ___ Allow _____ for make-up work
- ___ Essential Work Only

Testing

- ___ Additional time to complete tests
- ___ No more than one test a day
- ___ No standardized testing until _____
- ___ Allow for scribe, oral response, and oral delivery of questions, if available

Physical Exertion

- ___ No physical exertion/athletics/PE
- ___ Walking in PE class or athletic practice only
- ___ Begin graduated return to play protocol
(This is only possible for students currently enrolled in PE or participating in athletics)

Additional Recommendation

Current Symptom List (the student is noting these today)

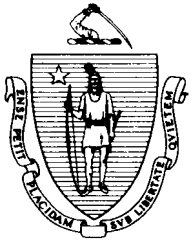
- | | | | |
|---------------|--------------------------|------------------------------|-------------------|
| ___ Headache | ___ Visual problems | ___ Sensitivity to noise | ___ Memory issues |
| ___ Nausea | ___ Balance problems | ___ Feeling foggy | ___ Fatigue |
| ___ Dizziness | ___ Sensitivity to light | ___ Difficulty concentrating | ___ Irritability |

Student is reporting more difficulty with/in

- | | | | |
|------------------|---------------------|----------------------|---------------|
| ___ All subjects | ___ Science/Math | ___ Foreign Language | ___ Reading |
| ___ Music | ___ Using Computers | ___ Focusing | ___ Listening |
| ___ Other: _____ | | | |

I, _____ give permission for Dr. _____ to share the following information with my child's school and for communication to occur between the doctor and the school for changes to this plan.

Parent Signature _____ Date _____ Physician Signature _____ Date _____



Mount Greylock Regional School & MA Department of Public Health



POST SPORTS-RELATED HEAD INJURY MEDICAL CLEARANCE AND AUTHORIZATION FORM

Student's Name	Sex	Date of Birth	Grade
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Date of injury: _____ Nature and extent of injury: _____

Symptoms following injury (check all that apply):

- | | | |
|--|---|--|
| <input type="checkbox"/> Nausea or vomiting | <input type="checkbox"/> Headaches | <input type="checkbox"/> Light/noise sensitivity |
| <input type="checkbox"/> Dizziness/balance problems | <input type="checkbox"/> Double/blurred vision | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Feeling sluggish/"in a fog" | <input type="checkbox"/> Change in sleep patterns | <input type="checkbox"/> Memory problems |
| <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Irritability/emotional ups and downs | <input type="checkbox"/> Sad or withdrawn |

Duration of Symptom(s): _____ Diagnosis: Concussion Other: _____

The student must be completely symptom free at rest, during exertion, and with cognitive activity prior to returning to full participation in extracurricular athletic activities.

The student will not be cleared if the Return to Play information below is not complete.

If concussion diagnosed, date student completed graduated return to play plan without recurrent symptoms: _____

- *Students not involved in an interscholastic athletic program or not currently enrolled in PE must complete the Return to Play Protocol with the physician.*
- *Students involved in one of those programs will be required to complete the attached RTP protocol if no date is listed above.*

Prior concussions (number, approximate dates): _____

I HEREBY AUTHORIZE THE ABOVE NAMED STUDENT FOR RETURN TO ATHLETIC ACTIVITY

Practitioner signature: _____ Date: _____

Print Name: _____

Physician Licensed Athletic Trainer Nurse Practitioner Neuropsychologist Physician Assistant

License Number: _____

Address: _____ Phone number: _____

I ATTEST THAT I HAVE RECEIVED CLINICAL TRAINING IN POST-TRAUMATIC HEAD INJURY ASSESSMENT AND MANAGEMENT APPROVED BY THE DEPARTMENT OF PUBLIC HEALTH* OR HAVE RECEIVED EQUIVALENT TRAINING AS PART OF MY LICENSURE OR CONTINUING EDUCATION.

Practitioner's initials: _____ * MDPH approved Clinical Training options can be found at: [www.mass.gov/dph/sports concussion](http://www.mass.gov/dph/sports%20concussion)

Type of Training: CDC on-line Clinician Training
 Other MDPH approved Clinical Training
 Other (Describe) _____

******This form is not complete without the practitioner's verification of such training.**