FOR VIEWING PURPOSES ONLY

PINELLAS COUNTY SCHOOLS

RETURN TO SCHOOL RELEASE POST-CONCUSSION DIAGNOSIS

Instructions: This form is to be completed by the student's physician and may need to be completed more than once. Email/fax completed form to Sara O'Toole, RN. Fax: (727) 588-6422. Email: otooles@pcsb.org

Student Name: _____ DOB: _____ School: _____

Grade: _____ Date of evaluation: _____ Date of next appointment: _____

The student named above has suffered a concussion and is currently under our care. During their recovery, the student is going to require varying degrees of physical and cognitive (thinking) rest in an effort to return them to their previous level of functioning. Symptoms of concussion/brain injury can be triggered or increased by school related activities. In addition, increased cognitive load such as prolonged concentration, loud noise, unpredictable environments and fatigue can worsen symptoms.

It is important to increase time at school and workload gradually, so symptoms are not increased or prolonged because of the school environment. When the student no longer requires any academic accommodations, they will begin the process of returning to sports activity. The recommendations below for academic accommodations will assist the teachers and student by advancing their cognitive lead (schoolwork, etc.) as their recovery allows.

The student's current symptoms include:

- ☐ Headache
- ☐ Fatigue
- ☐ Balance Issues
- ☐ Visual Disturbance
- ☐ Sensitivity to light
- ☐ Sensitivity to noise
- ☐ Difficulty with concentration

The academic accommodations listed below are recommended and will be updated during the patient's next formal evaluation. This release expires on the date of the next appointment identified above.

Student is cleared to return to school with the following supports on: _____ (date)

- ☐ _____ hours per day
- ☐ Half days as tolerated
- ☐ Return to full days of school, after completing a half-day without increase in symptoms
- ☐ No gym class, recess, strenuous physical activity or sports
- ☐ Excuse from other non-sport extracurricular activity
- ☐ Early release from class by 3-5 minutes
- ☐ No choir, band or music classes
- ☐ Allow short rest breaks in a quiet area of the school
- ☐ Access to a quiet, restful place during lunch
- ☐ Opportunity to obtain class notes or outline ahead of time
- ☐ Limit exposure to computer screens
- ☐ Reduce overall amount of make-up work, class work, and homework by _____%
- ☐ Access to a guidance counselor to develop a plan for missed work.
- ☐ Extra time for testing or testing across multiple sessions
- ☐ No tests or quizzes

☐ **Student is cleared to return to full school activities without accommodations.**

Thank you for your cooperation and support of this student during their recovery time.

CLINIC STAMP BELOW

Treating physician (signature): _____ MD / DO

Printed name: _____

I, the parent, agree that the school may implement the accommodations identified herein.

Parent (signature): _____ Printed name: _____