



CONCUSSION "RETURN TO LEARN" / PHYSICIAN RECOMMENDED SCHOOL ACCOMMODATIONS

Student Name: _____ Date of Birth: _____ Date of Evaluation: _____

This patient has been diagnosed with a concussion (brain injury) and is under my care. Please excuse from school during appointment times. Flexibility and support are needed during recovery. The following suggested adjustments can be individualized for this student, as deemed appropriate in school setting within initial 4 week period. If prolonged longer, refer for 504 eligibility.

Anticipated Symptoms: Sensitivity to: ☐ Light ☐ Sound; Difficulty with: ☐ Sleep ☐ Concentration ☐ Memory ☐ Balance
☐ Irritability ☐ Headache ☐ Dizziness ☐ Visual problems ☐ Nausea ☐ Feeling foggy ☐ Fatigue

Area	Requested Modifications [check applicable boxes <input type="checkbox"/>	Comments
Attendance	<input type="checkbox"/> <u>Standard Recommendations:</u> No school for 24 hours after concussion; Once student tolerates a 15 minute walk without symptoms, can begin school. Start with half-day school and then progress to full days, as tolerated. <input type="checkbox"/> Dismiss student before/after class to avoid crowds	
Observation	<input type="checkbox"/> School staff to help identify aggravators, to reduce exposure (<i>e.g., bright lights, noisy hallways, attention to school work longer than 20 minutes</i>)	
Breaks	<input type="checkbox"/> Anticipate breaks during school day <input type="checkbox"/> Mandatory breaks every: _____ <input type="checkbox"/> If symptoms appear/worsen during class, allow rest in nurse's office; If no improvement after 30 minutes, allow dismissal to home <input type="checkbox"/> Water bottle in class / Snack every 3-4 hours	
Visual Stimuli	<input type="checkbox"/> Allow sunglasses/Hat <input type="checkbox"/> Digital text / Text to Voice (<i>e.g., Dragon</i>) <input type="checkbox"/> Larger font for written materials <input type="checkbox"/> Change classroom seating, as needed <input type="checkbox"/> Pre-printed class notes or note taker <input type="checkbox"/> Limit time and/or brightness of monitors/screens	
Auditory Stimuli	<input type="checkbox"/> Avoid loud classroom activities, music/band, wood/metal shop, choir, gym <input type="checkbox"/> Lunch and recess in quiet place (with a friend) <input type="checkbox"/> Allow to wear earplugs, as needed <input type="checkbox"/> Allow class transitions before bell	
School work and Testing	<i>Anticipate this student's temporary reduced ability for the following:</i> <input type="checkbox"/> In-class work <input type="checkbox"/> Homework <input type="checkbox"/> Test-taking <i>Consider:</i> <input type="checkbox"/> Simplifying tasks and instructions <input type="checkbox"/> Additional time to take test <input type="checkbox"/> Alternative test methods (oral delivery, oral response, scribe) <input type="checkbox"/> Maximum one test per day <input type="checkbox"/> Referral for 504 eligibility, if prolonged	
Physical Activity	<input type="checkbox"/> No exertive physical activity until academically back to normal [For maximum of 2 weeks; then individualize as per rehab specialist] <u>Follow the attached Return to Play protocol:</u> <input type="checkbox"/> General activity form <input type="checkbox"/> CIF form <input type="checkbox"/> Sport specific form	

PARENT/GUARDIAN: I give permission for the exchange of information between the school and my child's physician for matters related to school accommodations following a concussion, allowing changes to this plan.

Name: _____ Signature: _____ Date: _____

This patient will be reassessed here for revision of these recommendations in _____ weeks/days. Please have a school representative send me (and parent) periodic updates on functioning in school, until student back to normal.

Physician Name (printed or stamp)

Physician Address (or stamp)

Physician Signature

Date