Return to Learn: Academic Accommodation Plan Following Concussion

(To be completed by medical provider)

This form should be brought to the school nurse immediately upon return to school to initiate the health alert process.

Student's name: _____ Date of birth: _____

The above student has been diagnosed with a concussion (also known as a mild traumatic brain injury). Following a concussion individuals need both cognitive and physical rest to allow for the best and quickest recovery. Therefore it is important to limit activities that require a lot of thinking or concentration, as this can make the symptoms worse.

The student is able to return to school (date) _____ with the following recommended supports:

_____ No supports necessary. Student has been released to return to full academic and athletic/physical fitness activities.

To promote cognitive rest:

_____ Allow for shortened school days. Recommended _____ hours per day until re-evaluated.

(Alternating days of morning/afternoon classes suggested if ≤4 hours/day recommended)

_____ Allow for shortened classes (i.e. rest breaks during class) Maximum class length _____ minutes.

_____ Allow extra time to complete coursework/assignments.

_____ No classroom or standardized testing at this time, as this does not reflect the student's true abilities.

_____ Limited classroom testing allowed. No more than _____ questions and/or _____ total time.

_____ Student is able to take quizzes or tests that are written but not bubble sheets.

_____ Student is able to take tests but should be allowed extra time to complete.

_____Lessen screen time (computer, videos, smartboard) to a maximum of _____ minutes per class AND

no more than _____ continuous minutes (with 5-10 minute break in between).

_____ Print class notes and online assignments (14 Font recommended)

_____ Lessen homework by _____% per class; or to a maximum of _____ total minutes nightly for all classes,

no more than _____ continuous.

To address sensitivity to noise and light:

_____ Provide alternative setting during band or music class (outside of band room or music classroom)

_____ Provide alternative setting during PE and recess to avoid noise exposure and risk of further injury (out of the gym.)

_____ Allow early class release for class transitions to reduce exposure to hallway noise.

_____ Provide alternative location to eat lunch outside the cafeteria.

_____ Allow the use of earplugs when in a noisy environment during the school day.

_____ Allow student to wear sunglasses or a hat with a bill worn forward to reduce light exposure.

To reduce risk of further injury:

- **Students participating on the school athletic teams will be working with their athletic trainers and medical provider on their Gradual Return to Play and completion of the Gfellar-Waller form.**
- **No student should return to full physical activity (PE, recess, etc) if ANY symptoms are present**
- **For non-athletes in elementary, middle or high school:**

  _____ No PE/Recess/Participation in any classes or events involving physical activity or on sports teams until re-evaluated.

_____ Patient has completed a return to play progression and is able to participate in PE/Recess/and any other classes or events involving physical activity as long as symptom free.

_____ Can return to PE class and/or recess after completing a return to play progression under the supervision of the teacher as follows: [Student should be progressed to the next day ONLY if they do not experience symptoms. If symptoms occur, rest one day and return to last day activity with no symptoms. If "re-start" twice, consult healthcare provider. ONCE THE BELOW RETURN TO ACTIVITY IS COMPLETED ALL ACADEMIC AND PHYSICAL RESTRICTIONS AND MODIFICATIONS ARE DISCONTINUED.

Day	**Activity**	**Comments**	**Supervised By**
1	20-30 minutes of cardio activity: i.e., walking or stationary bike. No swings/monkey bars. No ball activities. Very light activity – not breathing hard. **Check with student every 20 minutes during activity. STOP if symptoms**		
2	30 minutes cardio: jogging, medium pace. Should do sit-ups, push-ups. Light weightlifting. No contact. Can shoot/dribble basketball if alone. Intensity: breathing heavier, still can talk while exercising. **Check with student every 20 minutes. STOP if symptoms**		
3	30 minutes cardio: faster pace jogging. Sit-ups, push-ups, change of direction drills (shuttle run). Ok for swings. Moderate weightlifting, no maxing. Intensity: Difficult for conversation. **Check with student every 20 minutes. STOP if symptoms**		
4	Warm-up, Able to run without restriction. Able to participate in sports, non-contact. Resume regular weightlifting. **Check with student every 20 minutes**		
5	Able to return to all activities. **Check with student every 20 minutes during activity to assure no return in symptoms**. **If occurs, STOP and see school nurse.**		

These recommendations are based on today's evaluation. Date: _____

Student is scheduled to return to this office. (Date or in approximate number of days/weeks) _____

Referral has been made to: Sports Medicine _____ Neurology _____ Physiatrist _____ Psychiatrist _____ other _____

Signature of medical provider: _____ MD DO NP PA-C

Name of provider (print): _____ Office phone: _____

To be completed by parent/guardian:

I agree with the above recommendations and would like them to be implemented: Yes _____ No _____

The best number to reach me during the day to discuss my child's plan for school is _____.

RELEASE OF INFORMATION: I give permission for the school nurse/school personnel to exchange information regarding my child's care following the concussion with the provider/office listed above. Yes _____ No _____

Parent signature: _____ Date: _____

Form was received and reviewed by school nurse. (date & signature) _____

Health alert process was initiated by the School Nurse (date) _____

Copy given to 504 coordinator per protocol (name & date) _____ 10/2015 KEB