

## SCHOOL RECOMMENDATIONS FOLLOWING CONCUSSION

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. Please excuse the patient from school today due to the medical appointment. 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. Feel free to apply/remove adjustments as needed as the student's symptoms improve/worsen.

### Attendance

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

### Visual Stimulus

- \_\_\_\_\_ Allow student to wear sunglasses/hat in school
- \_\_\_\_\_ Pre-printed notes for class material or note taker
- \_\_\_\_\_ Limited computer, TV screen, bright screen use
- \_\_\_\_\_ Reduce brightness on monitors/screens
- \_\_\_\_\_ Change classroom seating as necessary

### Workload/Multi-Tasking

- \_\_\_\_\_ Reduce overall amount of make-up work, class work and homework
- \_\_\_\_\_ Prorate workload when possible
- \_\_\_\_\_ Reduce amount of homework given each night

### Physical Exertion

- \_\_\_\_\_ No physical exertion/athletics/gym/recess
- \_\_\_\_\_ Walking in gym class only
- \_\_\_\_\_ Begin return to play protocol as outlined by return to activity form

### 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 other breaks during school day as deemed necessary and appropriate by school personnel

### 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

### 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

### Additional Recommendations

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Current Symptoms 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 most difficulty with/in

- |                    |                             |                        |                       |
|--------------------|-----------------------------|------------------------|-----------------------|
| _____ All subjects | _____ Reading/Language arts | _____ Foreign Language | _____ Math            |
| _____ Science      | _____ Music                 | _____ History          | _____ 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 school and Dr. \_\_\_\_\_ for changes to this plan

\_\_\_\_\_, MD

Office ( ) - Fax ( ) -

Parent Signature \_\_\_\_\_ Date \_\_\_\_\_