Health Care Plan following a suspected concussion

Student Name: _____ School: _____ Date: _____ ***Date of Injury***: _____

Parent/Guardian Name: _____ Parent/Guardian Phone: _____

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*Healthcare Provider Name: _____ Clinic's Name: _____ Clinic Phone: _____

Date of Concussion Diagnosis: _____ **(*Accommodations can be modified as the student's symptoms improve/worsen)***

*The above named student has been diagnosed with a concussion (a brain injury) and is currently under our care. Classroom flexibility, accommodations and additional supports are needed during recovery. The following are suggestions for academic accommodations to be individualized for the student as deemed appropriate in the school setting.

Area	Requested Accommodations RETURN TO LEARN PROTOCOL - RTL	Comments
Attendance	☐ No School ☐ Partial school day as tolerated by student—emphasis on core subject work *encouraged classes:* _____ *discouraged classes:* _____ ☐ Half school days (alternate half days mornings and afternoons, if possible) ☐ Full school days as tolerated by student (note accommodations in comment section) ☐ Allow water bottle in classes and a snack every 2 - 4 hours	
Breaks	☐ If symptoms appear or worsen during class, allow student to go to a supervised quiet area or nurse's office. **If no improvement in symptoms within 30-60 minutes, allow dismissal home.* ☐ *Mandatory Breaks:* _____ ☐ Allow breaks during day as deemed necessary by student or teachers/school personnel	
Visual Stimulus	☐ Enlarged print (18 font) copies of textbook material/assignments/preprinted notes. Use of soft colored paper for reading (pastels) ☐ Note taker for in class materials ☐ Limited computer/TV screen, bright screen use (reduce brightness setting on monitors/screens), limit PowerPoint presentations ☐ Allow handwritten assignments (as opposed to typed on a computer) ☐ Allow student to wear brimmed hat in school, seat student away from windows and bright lights ☐ Change classroom seating to front of room as needed	
Auditory Stimulus	☐ Avoid noisy classroom activities and loud classes and/or places (i.e. music or shop class, cafeteria, gym, etc.) ☐ Lunch in a quiet place (with a friend - avoid social isolation) ☐ Allow student to wear earplugs (or unplugged earbuds) as needed ☐ Allow class transitions **before** the bell (avoiding noisy, congested hallways)	
School Work	☐ Simplify tasks (i.e. three (3) step instructions) ☐ Short breaks (5 min.) between tasks ☐ Reduce overall amount of in-class work ☐ Prorate workload (only core or essential tasks) and/or *eliminate non-essential work* ☐ No homework ☐ Reduce amount of nightly homework (ex: _____ minutes/class, _____minutes max/night, break every _____ minutes) ☐ Attempt homework, will stop if symptoms occur ☐ Extra tutoring/assistance requested ☐ May begin make-up of essential class work	
Testing	☐ No Testing ☐ Additional time for testing/untimed testing ☐ Alternative testing methods: oral delivery of questions, oral response, and/or scribe ☐ No more than one test a day ☐ No standardized testing	
Educational Plan	☐ Student is in need of a formal site-based academic support plan ☐ Consider evaluation for a 504 plan if prolonged symptoms (usually >month) are interfering with academic performance	
Physical Activity	☐ No physical exertion - including athletics, gym/PE, recess, band, choir and/or other _____ ☐ Untimed walking in PE class/recess ONLY ☐ **May begin graduated Return to Play protocol**	
Other		

The patient will be reevaluated at a follow up appointment for revision of these accommodations in _____ weeks. (date of appointment: _____)

If student fails to follow up as scheduled, the student may not be allowed to progress to the return to participation stage, and accommodations may be removed

I, _____, give permission for the licensed healthcare provider (LHP) to share the above information with my child's school & for communication to occur between the school & LHP for changes to this plan.

(parent/legal guardian name printed)

Parent/Guardian Name (Print): _____ Sign: _____ Date: _____

School Nurse Name (Print): _____ *Sign:* _____ *Date:* _____

LHP - Licensed Healthcare Provider (Print): _____ *Sign:* _____ *Date:* _____

The student is now released back to academic activities without accommodations & may begin the physically exertional return to play protocol on _____

LHP Initial & date