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

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

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

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

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

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

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

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. XXXXXXXXX to share the following information with my child's school and for communication to occur between the school and Dr. XXXXXXX for changes to this plan

_____
XXXXXXXXXXX, MD
XXXXXXXXXXXXXXXXXXX
Office (XXX)XXX-XXXX Fax (XXX)XXX-XXXX

_____
Parent Signature Date

This form may be duplicated or changed to suit your needs and your patients' needs.