

## 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  $\leq 4$  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. <b>Check with student every 20 minutes during activity. STOP if symptoms</b>		
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. <b>Check with student every 20 minutes. STOP if symptoms</b>		
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. <b>Check with student every 20 minutes. STOP if symptoms</b>		
4	Warm-up, Able to run without restriction. Able to participate in sports, non-contact. Resume regular weightlifting. <b>Check with student every 20 minutes</b>		
5	Able to return to all activities. <b>Check with student every 20 minutes during activity to assure no return in symptoms. If occurs, STOP and see school nurse.</b>		

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) \_\_\_\_\_