

SCHOOL RECOMMENDATIONS FOLLOWING CONCUSSION

This form must be filled out by a licensed healthcare provider.

Student Name _____ Date _____

Date of Injury _____ Healthcare Provider _____

Attendance		Breaks	
	No school for ____ day(s)		Allow the student to go to the nurse's office if symptoms increase
	Attendance at school ____ days per week		
	Partial work days as tolerated by the student		Allow student to go home if symptoms do not subside
	Full work days as tolerated by the student		
Visual Stimulus			Allow other breaks during school day as deemed necessary and appropriate by _____
	Allow student to wear sunglasses/hat in school		
	Pre-printed notes for class material or have a note taker	Audible Stimulus	
	Limited computer, TV screen, bright screen use		Lunch in a quiet place with a friend
	Reduce brightness on monitor/screen		Avoid music or shop class
	Change classroom seating as necessary		Allow to wear earplugs as needed
			Allow class transitions before bell
Workload/Multi-Tasking		Physical Exertion	
	Reduce overall amount of makeup work, class work and homework		No physical exertion/athletics/gym/recess
	Prorate workload when possible		Walking in gym class only
	Reduce amount of homework given each night		Begin Stage 1 Return to Play: Begin gentle cardio (stationary bike, easy jog)
Testing		Additional Recommendations/Restrictions	
	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		

The patient will be reassessed for revision of the recommendations in _____ weeks. This patient has been diagnosed with a concussion (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 above are recommendations 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.

I, _____, give permission for _____ to share the above information with my child's school and for communication to occur between the school and the healthcare provider listed above.

Parent Signature _____ Date _____

Provider Name _____ Phone _____ Fax _____

Provider Signature _____ Date _____

Save the Brain Concussion Clinic (406) 758-7035

logan.org/savethebrain