



# RETURN TO SCHOOL AFTER CONCUSSION

Student Name \_\_\_\_\_ Birthdate \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

## Date of Concussion

A concussion is a mild injury to the brain that temporarily changes how the brain normally works. It is usually caused by a sudden blow or jolt to the head, although children often bump or hit their heads without getting concussions. Signs and symptoms of a concussion include dizziness, headache, vomiting, confusion, acting dazed, forgetting what happened before or after the injury, and being "knocked out." A person does NOT need to be knocked out or lose consciousness to have had a concussion. Other words or terms for a concussion include mild traumatic brain injury (mild TBI) and mild closed-head injury.

Student may return to school on (Date) \_\_\_\_\_

## PHYSICAL ACTIVITY

- Student is FULLY limited and can NOT participate in any activities
- Student is PARTIALLY limited and can participate in the following activities only: \_\_\_\_\_
- YES, Student can return to RECESS and PE activities
- Student has NO limitations and can return to full participation

## ACADEMIC ACTIVITY

- Student may return to full participation without limitations.
- The following cognitive accommodations are recommended for this student:
  - Gradual re-integration to school (e.g., student returns part-time before resuming a full schedule)
  - Student not asked to do all missed work
  - Rest time or breaks as needed during the day
  - Overall homework and class work load reduced
  - No use of computer or other video equipment until after \_\_\_\_\_ (DATE)
  - No testing until after \_\_\_\_\_ (DATE)
  - Other: \_\_\_\_\_

Student has been counseled on how to self-manage this concussion  Yes  No

Student may resume full participation in all activities after \_\_\_\_\_ (DATE)

Student is to be re-evaluated on \_\_\_\_\_ (DATE) and may NOT resume full participation until cleared.

HEALTH CARE PROVIDER COMMENTS

Health Care Provider's Signature \_\_\_\_\_ Telephone \_\_\_\_\_ Fax \_\_\_\_\_

Health Care Provider's Printed Name or Stamp \_\_\_\_\_ Date \_\_\_\_\_

ROUTING	PARENT	TRANS	NURSE	TEACHER	PE	SPEC	HRA	KITCHEN	SEC-PRINCIPAL
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