SCHOOL ACADEMIC RECOMMENDATION FOLLOWING CONCUSSION

Patient name: _____
Date of Evaluation: _____
Duration of Recommendations: 1 week 2 weeks 3 weeks Until further notice
This 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. Flexibility and additional support are needed during recovery. The following are suggestions for academic adjustments to be individualized for the student as deemed appropriate in the school setting. Recommendations may be adjusted as needed as the student's symptoms improve/worsen.

Attendance

_____ No school ___ 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 student to go to nurses' office if symptoms worsen
____ Allow breaks during school as necessary
____ Allow student to go home if symptoms do not subside

Visual Stimulus

___ Allow student to wear sunglasses/hat in school
_____ Teacher's notes for class material or note taker
_____ Limited computer, TV screen, bright screen use
_____ Change classroom seating as necessary

Audible Stimulus

____ Lunch in a quiet place with a friend
____ Avoid music or shop class
____ Allow to wear earplugs as needed
____ Allow extra time between classes

Workload/Multi-Tasking

_____ Reduce overall amount of make-up work, class work, & homework_____
_____ Prorate workload when possible
_____ Reduce amount of homework given each night
_____ Allow for scribe, oral response, & oral delivery of questions, if available

Testing

____ No testing
____ Additional time to complete tests
____ No more than one test a day
____ No standardized testing until _____

Physical Exertion

_____ No physical exertion/athletics/gym/recess
_____ Light aerobic activity during PE
_____ Begin return-to-play protocol

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	____ Computers
____ Focusing	____ Listening	Other: _____	

_____
Physician signature **Date**
office stamp/phone:

I, _____, give permission for Dr._____ to share information Physician **with High School Dist 219 for educational planning purposes and for mutual communication to occur.**

_____
Parent Signature Date