SAVE THE BRAIN

SCHOOL RECOMMENDATIONS FOLLOWING CONCUSSION

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

Student Name_____ Date_____

Date of Injury_____ Healthcare Provider_____

Attendance	
	No school for ____ day(s)
	Attendance at school _____ days per week
	Partial school days as tolerated by the student
	Full school days as tolerated by the student
Visual Stimulus	
	Allow student to wear sunglasses/hat in school
	Pre-printed notes for class material or have a note taker
	Limited computer, TV screen, bright screen use
	Reduce brightness on monitor/screen
	Change classroom seating as necessary
Workload/Multi-Tasking	
	Reduce overall amount of makeup 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

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 _____
Audible Stimulus	
	Lunch in a quiet place with a friend
	Avoid music or shop class
	Allow to wear earplugs as needed
	Allow class transitions before bell
Physical Exertion	
	No physical exertion/athletics/gym/recess
	Walking in gym class only
	Begin Stage 1 Return to Play: Begin gentle cardio (stationary bike, easy jog)
Additional Recommendations/Restrictions	

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

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