SWEETWATER
UNION HIGH SCHOOL DISTRICT

CONCUSSION "RETURN TO LEARN" / PHYSICIAN RECOMMENDED SCHOOL ACCOMMODATIONS

Student Name: _____ Date of Birth:_____ Date of Evaluation:_____

This patient has been diagnosed with a concussion (brain injury) and is under my care. Please excuse from school during appointment times. Flexibility and support are needed during recovery. The following suggested adjustments can be individualized for this student, as deemed appropriate in school setting within initial 4 week period. If prolonged longer, refer for 504 eligibility.

☐ Anticipated Symptoms: **Sensitivity to**: ☐ Light ☐ Sound **Difficulty with**: ☐ Sleep ☐ Concentration ☐ Memory
☐ Balance ☐ Irritability ☐ Headache ☐ Dizziness ☐ Visual problems ☐ Nausea ☐ Feeling foggy ☐ Fatigue

Area	Requested Modifications [check applicable boxes ☐]	Comments
Attendance	☐ Standard Recommendations: No school for 24 hours after concussion; Once student tolerates a 15 minute walk without symptoms, can begin school. Start with half-day school and then progress to full days, as tolerated. ☐ Dismiss student before/after class to avoid crowds	
Observation	☐ School staff to help identify aggravators, to reduce exposure (e.g., bright lights, noisy hallways, attention to school work longer than 20 minutes)	
Breaks	☐ Anticipate breaks during school day ☐ Mandatory breaks every: _____ ☐ If symptoms appear/worsen during class, allow rest in nurse's office; If no improvement after 30 minutes, allow dismissal to home ☐ Water bottle in class / Snack every 3-4 hours	
Visual Stimuli	☐ Allow sunglasses/Hat ☐ Digital text / Text to Voice (e.g., Dragon) ☐ Larger font for written materials ☐ Change classroom seating, as needed ☐ Pre-printed class notes or note taker ☐ Limit time and/or brightness of monitors/screens	
Auditory Stimuli	☐ Avoid loud classroom activities, music/band, wood/metal shop, choir, gym ☐ Lunch and recess in quiet place (with a friend) ☐ Allow to wear earplugs, as needed ☐ Allow class transitions before bell	
School work and Testing	**Anticipate this student's temporary reduced ability for the following**: ☐ In-class work ☐ Homework ☐ Test-taking **Consider**: ☐ Simplifying tasks and instructions ☐ Additional time to take test ☐ Alternative test methods (oral delivery, oral response, scribe) ☐ Maximum one test per day ☐ ***Referral for 504 eligibility, if prolonged***	
Physical Activity	☐ No exertive physical activity until academically back to normal ☐ [For maximum of 2 weeks; then individualize as per rehab specialist] ***Follow the attached Return to Play protocol:*** ☐ General activity form ☐ CIF form ☐ Sport specific form	

PARENT/GUARDIAN: I give permission for the exchange of information between the school and my child's physician for matters related to school accommodations following a concussion, allowing changes to this plan.

Name:_____ Signature:_____ _____ Date:_____

This patient will be reassessed here for revision of these recommendations in _____ weeks/days. Please have a school representative send me (and parent) periodic updates on functioning in school, until student back to normal.

_____	_____	_____	_____
Physician Name (printed or stamp)	Physician Address (or stamp)	Physician Signature	Date