YUMA SCHOOL DISTRICT ONE
SCHOOL RECOMMENDATIONS FOLLOWING A CONCUSSION

Patient Name:_____ Date:_____

PARENT - PLEASE COMPLETE ON THE DAY OF YOUR CHILD'S MEDICAL EVALUTION

Current symptoms

- ☐ Headache
- ☐ Nausea
- ☐ Dizziness
- ☐ Balance Problems
- ☐ Visual Problems
- ☐ Light sensitive
- ☐ Noise sensitive

My child is reporting most difficulty with/in:

- ☐ All subject
- ☐ Reading
- ☐ Math
- ☐ Foreign Language
- ☐ Science
- ☐ History
- ☐ Music
- ☐ PE
- ☐ Using computers
- ☐ Feeling Foggy
- ☐ Fatigue
- ☐ Concentrating
- ☐ Noise Sensitive
- ☐ Light Sensitive
- ☐ Forgetfulness
- ☐ Focusing
- ☐ Listening
- ☐ Irritability
- ☐ Emotional

HEALTHCARE PROVIDER - PLEASE COMPLETE FOR SCHOOL RECOMMENDATIONS

Date of Evaluation:_____

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 a medical appointment. Flexibility and additional supports may be needed during recovery. The following are suggestions for academic adjustments to be indiviualized for the student as deemed appropiate in the school setting.

Attendance

- ☐ No school for _____day(s)
- ☐ Attendance at school _____ day(s) per week
- ☐ Full days as tolerated by the student
- ☐ Partial days as tolerated by the student (_____hrs per day)

Breaks

- ☐ Allow the student to go to the health office if symptoms increase
- ☐ Allow student to go home is symptoms do not subside
- ☐ Allow breaks during school as deemed necessary by staff

Visual Stimulus

- ☐ Allow student to wear sunglasses/hat in school
- ☐ Pre-print notes for class material or note taker
- ☐ Limit computer or screen use
- ☐ Reduce brightness on monitors

Audible Stimulus

- ☐ Lunch in quiet place with a friend
- ☐ Avoid music or loud places
- ☐ Allow to wear earplugs as needed
- ☐ Allow class transitions before the bell

Workload/Multi-tasking

- ☐ Reduce overall amount of make-up work and class work
- ☐ Prorate workload when possible
- ☐ Reduce amount of homework (max 1 hr per night)

Testing

- ☐ Allow additional time to complete quiz/tests
- ☐ No more than one test per day
- ☐ No standardized testing until _____
- ☐ Allow for scribe, oral response, and oral delivery if available

Physical Exertion

- ☐ No PE, athletics, or recess
- ☐ Walking in PE class only

Additional Recommendations

_____

_____

Duration of Recommendation: ☐ 1 week ☐ 2 weeks ☐ 3 weeks ☐ Other_____

The patient will be reassessed for revision of these recommendations in _____ weeks. **Next Appointment Date:**_____

_____ _____ _____

Healthcare Provider's Signature **Healthcare Provider (print name)** **Date**

_____ _____

Healthcare Provider's Address **HCP Phone Number**

PARENT SIGNATURE

I (parent print) _____ give permission to release my child's medical information regarding their concussion diagnosis and treatment between the healthcare provider and school health office. This medical release will expire at the end of the current school year.

Parent Signature_____ Parent Phone Number _____ Date_____