Riverside Brookfield High School (Form #4)
Concussion "Return to Learn" / Physician Recommended School Accommodations

Student Name:___________________________________ Date of Birth:_________ Grade: _________
Date: ________________________ Concussion Date: ________________________

This patient has been diagnosed with a concussion and is currently under our care. Please excuse from school during appointment times. Flexibility and support are needed during recovery. The following are suggested academic accommodations to be individualized for the student, as deemed appropriate in the school setting.

Anticipated Symptoms: ***Sensitivity to***: __ Light __ Sound; ***Difficulty with***: __Sleep __Concentration __Memory __Balance __Irritabilty __Headache __Dizziness __Visual problems __Nausea __Fatigue __ Feeling Foggy

Area	Requested Accommodations	Duration/Comments
Attendance	__Standard Recommendation: No School for 24 hours after concussion; Once student tolerations a 15-minute walk without symptoms, can begin school. Start with half-day and then progress to full days as tolerated. __Dismiss student before/after school to avoid crowds and sound in halls	
Breaks	__Anticipate breaks during the school day depending on speed of recovery __Mandatory breaks every: ____ minutes __If symptoms appear/worsen during class, allow rest in the nurse's office __Allow water and snacks in class as needed	
Visual Stimuli	__Allow sunglasses/hat in class __Provide larger font for written materials __Change seating, as needed based on light and sound sensitivity __Provide classroom notes or a note-taker __Limit time and/or brightness of monitors/screen	
Auditory Stimuli	__Avoid loud classroom activities (music,band, PE, choir, etc) __Provide alternative setting for lunch to avoid cafeteria noise __Allow to wear earplugs, as needed	
School Work & Testing	__Reduce in-class work __Reduce homework to _____ minutes max total, per night __No homework __No classroom tests __No standardized tests __Allow additional time on tests __Provide alternative test methods __Maximum of one test per day	
Physical Activity	__No PE until cleared by their physician or athletic trainer working under a physician for all sports and physical activities	

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.
Name: ___________________________________Signature:________________________________
Date:___________

This patient will be reassessed her for revision of these recommendations in __________weeks.

______________________________________ Physician Name (printed or stamp)

____ Address (printed or stamp)

______________________________________ Physician Signature

____ Date