

Exhibit – Concussion Form for Students Who Do Not Participate in Interscholastic Athletic Activities (NEW)

Request for Accommodations after Concussion

**Student Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**School Monitoring:**

- The student will check-in daily with the school nurse (staff) to monitor concussion-related symptoms.
- If an activity results in worsening symptoms, time spent engaging in that activity should be reduced.
- Worsening symptoms will be promptly reported to the parent/guardian.

Most students with a concussion feel better within 2 - 4 weeks. **New, ongoing, or worsening symptoms should be re-evaluated by their physician, physician assistant, or advanced practice registered nurse, who may refer them to a brain injury specialist.**

The accommodations below should remain in effect for **(ONE BOX MUST BE CHECKED)**:

1 week     2 weeks     4 weeks     until re-evaluation in my office  
on: \_\_\_\_\_

**Physician, PA, APRN**

Printed name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

Contact information: \_\_\_\_\_

**Parent/Guardian**

I consent to the sharing of relevant medical information between the school and the physician's office for the purpose of concussion management.

Printed name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_

<b>Recommended Academic Accommodations</b> Provided for the Student as needed with a gradual weaning until baseline is reached.			<b>Physical Activity Restrictions</b>
<b><u>ATTENDANCE &amp; BREAKS</u></b>	<b><u>HOMEWORK &amp; TESTING</u></b>	<b><u>VISUAL/AUDIO</u></b>	<b><u>PHYSICAL ACTIVITY</u></b>
<input type="checkbox"/> No school until: _____, then start: <input type="checkbox"/> Minimal hours (1-3 hours) <input type="checkbox"/> Reduced hours (4-6 hours) <input type="checkbox"/> Full hours (7+ hours) <input type="checkbox"/> Rest breaks as needed in a quiet location <input type="checkbox"/> Scheduled rest breaks every _____ hours for _____ minutes <input type="checkbox"/> No breaks needed	<input type="checkbox"/> No homework <input type="checkbox"/> Reduced homework <input type="checkbox"/> Extended deadlines for homework <input type="checkbox"/> Full homework <input type="checkbox"/> No classroom tests <input type="checkbox"/> Condensed tests <input type="checkbox"/> Extra time for tests <input type="checkbox"/> Tests in quiet area <input type="checkbox"/> Extended deadlines for tests <input type="checkbox"/> No standardized tests <input type="checkbox"/> Regular testing <input type="checkbox"/> Reduced make-up work	<input type="checkbox"/> No screens/computers <input type="checkbox"/> Reduced screen time <input type="checkbox"/> No visual restrictions <input type="checkbox"/> Reduced reading <input type="checkbox"/> Provide audio-books (if available) <input type="checkbox"/> Provide printed notes (if available) <input type="checkbox"/> Allow tinted glasses <input type="checkbox"/> Allow earplugs <input type="checkbox"/> Eat in quiet space <input type="checkbox"/> Access to treatment medication for headache (MUST include Unit 5 Medication Form)	<input type="checkbox"/> No PE/recess/sports <input type="checkbox"/> PE/recess - limited to walking only <input type="checkbox"/> PE/recess - light activity (no contact) <input type="checkbox"/> PE/recess - gradually increase activity as tolerated <input type="checkbox"/> No after-school extracurricular clubs or activities
Other Accommodations Requested: _____ _____ _____			For additional information visit: <a href="http://www.cdc.gov/HEADSUP">www.cdc.gov/HEADSUP</a>