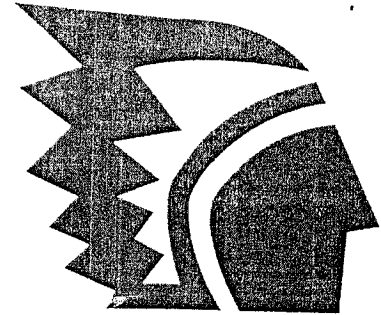


# Anna District #37

## Return to Play & /Return to Learn Report



### SCHOOL RECOMMENDATIONS

Patient Name: \_\_\_\_\_

Date of Evaluation: \_\_\_\_\_

Provider's Signature: \_\_\_\_\_

This patient has been diagnosed with a concussion and is currently under our care. Please excuse the patient from school today due to a medical appointment. It is suggested that the following recommendations be implemented to avoid increasing concussion symptoms and delaying recovery.

Please allow the following academic recommendations from \_\_\_\_\_ thru \_\_\_\_\_  
(Please see reverse side for additional information) \_\_\_\_\_

#### Attendance

- No school for \_\_\_\_\_ school day(s)
- Part time attendance for \_\_\_\_\_ school day(s) as tolerated
- Full school days as tolerated
- Tutoring homebound/in school as tolerated
- No school until symptom free or significant decrease in symptoms

#### Breaks

- Allow student to go to the nurse's office if symptoms increase
- Allow student to go home if symptoms do not subside

#### Visual Stimulus

- Allow student to wear sunglasses in school
- Pre-printed notes for class material or note taker
- No smart boards, projectors, computers, TV screens or other bright screen
- Enlarged font when possible

#### Audible Stimulus

- Allow student to leave class 5 minutes early to avoid noisy hallway
- Lunch in a quiet place
- Audible learning (discussions, reading out loud, if possible text to speech programs or Kindle)

#### Workload/Multi-Tasking

- Reduce overall amount of make-up work, class work and homework when possible
- No homework
- Limit homework to \_\_\_\_\_ minutes a night
- Prorate workload when possible

#### Testing

- No testing
- Extra time to complete tests
- No more than one test a day
- Oral testing
- Open book testing

#### Physical Exertion

- No physical exertion/athletics/gym
- Begin return to play protocol prior to returning to gym or athletics

#### Additional Recommendations

- Other: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

#### Current Symptom List (the patient is complaining today of)

- |  |   |   |   |
|--|---|---|---|
| <input type="checkbox"/> Headache        | <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Sensitivity to light   | <input type="checkbox"/> Trouble falling asleep   |
| <input type="checkbox"/> Visual problems | <input type="checkbox"/> Difficulty remembering   | <input type="checkbox"/> Sensitivity to noise   | <input type="checkbox"/> Drowsiness               |
| <input type="checkbox"/> Dizziness       | <input type="checkbox"/> Feeling slowed down      | <input type="checkbox"/> Feeling more emotional | <input type="checkbox"/> Sleeping less than usual |
| <input type="checkbox"/> Nausea          | <input type="checkbox"/> Feeling mental foggy     | <input type="checkbox"/> Irritability           | <input type="checkbox"/> Sleeping more than usual |
| <input type="checkbox"/> Fatigue         | <input type="checkbox"/> Balance Problems         |   |   |

The patient has been scheduled for a follow-up medical appointment and revision of recommendations on \_\_\_\_\_