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**Return to Learn After Concussion**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth \_\_\_\_\_\_\_\_\_\_\_Date of Evaluation:\_\_\_\_\_\_\_\_\_\_

Duration of Recommendations: 1 week 2 weeks 4 weeks Until further notice

The patient will be reassessed for revision of these recommendations in \_\_\_\_\_\_\_\_weeks.

This patient has been diagnosed with a concussion (a brain injury) and is currently under our care. Flexibility and additional supports are needed during recovery. The following are suggestions for academic adjustments to be individualized for the student as deemed appropriate in the school setting.



**Attendance** **Visual Stimulus**

\_\_\_\_ No School for \_\_\_\_ school days(s) \_\_\_\_ Allow student to wear sunglasses in school.

\_\_\_\_ Attendance at School \_\_\_\_\_\_ days per week \_\_\_\_ Provide pre-printed notes of class material

\_\_\_\_ Full School days as tolerated by the student \_\_\_\_ Limited Computer/TV screen use to \_\_\_\_\_\_ minutes at a time.

\_\_\_\_ Partial days as tolerated by the student \_\_\_\_ Reduce brightness on monitor/screens

\_\_\_\_ Allow change in classroom seating as necessary

**Physical Exertion Breaks**

\_\_\_\_ No physical exertion/athletics/gym/recess \_\_\_\_ Allow the student to go to nurse’s office if symptoms increase

\_\_\_\_ Walking in gym class only \_\_\_\_ Allow student to go home if symptoms do not subside

\_\_\_\_ Begin return to play protocol as outlined by \_\_\_\_ Allow other breaks during school day as deemed necessary Montana Return To Play Guidelines and appropriate by school personnel

\_\_\_\_ Please allow patient to take medication at school as directed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Audible Stimulus Workload/Multi-Tasking**

\_\_\_\_ Lunch in a quiet place with a friend **\_\_\_\_** Reduce overall amount of make-up work, class/home work

\_\_\_\_ Avoid music or shop classes \_\_\_\_ Reduce amount of homework given each night\_\_\_\_ Allow to wear earplugs as needed

\_\_\_\_ Allow class transitions before bell

**Testing**

\_\_\_\_ Additional time to complete test \_\_\_\_ Allow for scribe or oral response \_\_\_\_ No more than one test a day \_\_\_\_ Please provide someone to read questions

\_\_\_\_ No standardized testing until \_\_\_\_\_\_

**Student is reporting most difficulty with:**

\_\_\_\_ Visual problems \_\_\_\_ Balance/dizziness problems \_\_\_\_ Sensitivity to light

\_\_\_\_ Sensitivity to noise \_\_\_\_ Feeling foggy \_\_\_\_ Concentration/Memory

\_\_\_\_ Headaches

Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_ Parent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_