SAN MARCOS UNIFIED SCHOOL DISTRICT
engaging students...inspiring futures

CONCUSSION "RETURN TO LEARN" / PHYSICIAN RECOMMENDED SCHOOL ACCOMMODATIONS

Student Name: _____ Date of Birth: _____ Date of Evaluation: _____

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

Anticipated Symptoms: Sensitivity to: ☐Light ☐Sound; Difficulty with: ☐ Sleep ☐Concentration ☐Memory ☐Balance ☐Irritability ☐Headache ☐Dizziness ☐Visual problems ☐Nausea ☐Feeling foggy ☐Fatigue

Area	Requested Modifications [check applicable boxes☐]	Comments
Attendance	☐Standard Recommendations: No school for 24 hours after concussion; Once student tolerates a 15 minute walk without symptoms, can begin school. Start with half-day school and then progress to full days, as tolerated. ☐Dismiss student before/after class to avoid crowds	
Observation	☐School staff to help identify aggravators, to reduce exposure (*e.g., bright lights, noisy hallways, attention to school work longer than 20 minutes)*	
Breaks	☐Anticipate breaks during the school day ☐ Mandatory breaks every: _____ ☐If symptoms appear/worsen during class, allow rest in nurse's office; If no improvements after 30 minutes, allow dismissal to home ☐Water bottle in class / Snack every 3-4 hours	
Visual Stimuli	☐Allow sunglasses/Hat ☐ Audiotapes (vs. books/computer) ☐Larger font for written materials ☐Change classroom seating, as needed ☐Pre-printed class notes or note taker ☐Limit time and/or brightness of monitors/screens	
Auditory Stimuli	☐Avoid loud classroom activities, music/band, wood/metal shop, choir, gym ☐Lunch and recess in quiet place (with a friend) ☐ wear earplugs, as needed ☐Allow class transitions before bell	
School work and Testing	☐Simplify tasks and instructions ☐ Reduce in-class work ☐Reduce homework (_____ minutes max total, per night) ☐No homework ☐No testing ☐No standardized tests ☐ Allow additional time to take test ☐Alternative test methods (oral delivery, oral response, scribe) ☐Maximum one test per day	
Physical Activity	☐No exertive physical activity until academically back to normal [For maximum of 2 weeks; then individualized as per rehab specialist] Follow the attached Return to Play protocol: ☐General activity ☐ CIF form ☐Sport specific	

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, allowing changes to this plan.

Name:_____ Signature:_____ Date:_____

This patient will be reassessed here for revision of these recommendations in _____ weeks/days. Please have a school representative send me (and parent) periodic updates on functioning in school, until student back to normal.

Physician Name (printed or stamp)	Physician Address (or stamp)	Physician Signature	Date