Concussion Return to School
Burris Laboratory School

Student:_____ DOB:_____
Provider:_____ Phone:_____
Provider's Signature:_____ Date:_____

The above named student has been diagnosed with a concussion and is currently under our care. Please excuse the student from school today. It is suggested that the following recommendations be implemented to avoid increasing concussion symptoms and delayed recovery.

Please allow the following academic recommendations from_____ to _____

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 so not subside

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

Audible Stimulus:
_____ Allow student to leave class 5 minutes early to avoid noisy hallway
_____ Lunch in a quiet space
_____ 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/PE class
_____ Begin return to play protocol prior to returning to PE or athletics

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Additional Recommendations:

_____

_____

Current Symptom List:

_____ Headache	_____ Difficulty Concentrating	_____ Sensitivity to light
_____ Visual Problems	_____ Difficulty remembering	_____ Sensitivity to noise
_____ Dizziness	_____ Feeling slowed down	_____ Feeling more emotional
_____ Nausea	_____ Feeling mental foggy	_____ Irritability
_____ Fatigue	_____ Balance Problems	_____ Trouble falling asleep
_____ Drowsiness	_____ Sleeping less than normal	_____ Sleeping more than normal

The student is scheduled for a follow up medical appointment and revision of recommendations on:_____.