TRI-VALLEY CUSD #3
410 E WASHINGTON ST | DOWNS, IL 61736 | 309.378.2351

SCHOOL RECOMMENDATIONS FOLLOWING CONCUSSION

Name: _____ Date of Birth: _____

Date of Evaluation: _____ Referred by_____

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. Please excuse the patient from school today due to the medical appointment. Flexibility and additional supports are needed during recovery. The following are suggestions for academic adjustmentsto be individualized for the student as deemed appropriate in the school setting. Feel free to apply/remove adjustments as needed as the student's symptoms improve/worsen.

Attendance

_____ No school for _____ school day(s)
_____ Attendance at school_____ days per week
_____Full school day as tolerated by the student
_____Partial days as tolerated by the student

Breaks

_____ Allow the student to go to the nurse's office if symptoms increase
_____ Allow student to go home if symptoms do not subside
_____Allow other breaks during school day as deemed necessary and appropriate by school personnel

Visual Stimulus

_____Allow student to wear sunglasses/hat in school
_____Pre-printed notes for class material or note taker
_____Limited computer, TV screen, bright screen use
_____Reduce brightness on monitors/screens
_____Change classroom seating as necessary

Audible Stimulus

_____Lunch in a quiet place with a friend
_____Avoid music or shop classes
_____Allow to wear earplugs as needed
_____Allow class transitions before bell

Workload/Multi-Tasking

_____Reduce overall amount of make-up work, class work and homework
_____Prorate workload when possible
_____Reduce amount of homework given each night

Testing

_____Additional time to complete tests
_____No more than one test a day
_____No standardized testing until _____
_____Allow for scribe, oral response, and oral delivery of questions, if available

Physical Exertion

_____No physical exertion/athletics/gym/recess
_____Walking in gym class only
_____Begin return to play protocol as outlined by return to activity form

Additional Recommendations

_____
_____
_____
_____

Tri-Valley Elementary School	Tri-Valley Middle School	Tri-Valley High School
Phone: 309-378-2031	Phone: 309-378-3414	Phone: 309-378-2911
Fax: 309-378-4578	Fax: 309-378-3214	Fax: 309-378-3202

Current Symptoms List (the student is noting these today)

___Headache ___Visual problems ___Sensitivity to noise ___Memory issues ___Nausea
___Balance problems ___Feeling foggy ___Fatigue ___Dizziness ___Sensitivity to light
___Irritability ____Difficulty concentrating

Student is reporting most difficulty with/in

___All subjects __Math __Science __Music __History __Using Computers __Focusing __Listening
__Reading/Language Arts __Foreign Language Other: _____

Physician Signature_____Date_____

I, _____, give permission for Dr. _____ to share the following information with my child's school and for communication to occur between the school and Dr. _____ for changes to this plan.

Parent Signature_____ Date_____