



Manatee County School Health Services



RETURN TO SCHOOL RELEASE POST-CONCUSSION DIAGNOSIS

Student Name: _____ DOB: _____ School: _____

Grade: _____ Date of evaluation: _____ Date of next appointment: _____

The student named above has suffered a concussion and is currently under our care. During their recovery, the student is going to require varying degrees of physical and cognitive (thinking) rest in an effort to return them to their previous level of functioning. Symptoms of concussion/brain injury can be triggered or increased by school related activities. In addition, increased cognitive load such as prolonged concentration, loud noise, unpredictable environments and fatigue can worsen symptoms.

It is important to increase time at school and workload gradually, so symptoms are not increased or prolonged because of the school environment. When the student no longer requires any academic accommodation, they will begin the process of returning to sports activity. The recommendations below for academic accommodations will assist the teachers and student by advancing their cognitive load (schoolwork, etc.) as their recovery allows.

The student's current symptoms include:

<input type="checkbox"/> Headache	<input type="checkbox"/> Sensitivity to light	<input type="checkbox"/> Visual Disturbance
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Sensitivity to noise	
<input type="checkbox"/> Balance Issues	<input type="checkbox"/> Difficulty with concentration	

The academic accommodations listed below are recommended and will be updated during the patient's next formal evaluation. This release expires on the date of the next appointment identified above.

Student is cleared to return to school with the following supports on: _____ (date)

<input type="checkbox"/> _____ hours per day	<input type="checkbox"/> Reduce overall amount of make-up work, class work, and homework by _____%
<input type="checkbox"/> Return to full days of school, after completing a half-day without increase in symptoms	<input type="checkbox"/> Half-days as tolerated
<input type="checkbox"/> No gym class, recess, strenuous physical activity or sports	<input type="checkbox"/> Excuse from other non-sport extracurricular activities
<input type="checkbox"/> Early release from classes by 3-5 minutes	<input type="checkbox"/> No choir, band or music classes
<input type="checkbox"/> Allow short rest breaks in a quiet area of the school	<input type="checkbox"/> Access to a quiet, restful place during lunch
<input type="checkbox"/> Opportunity to obtain class notes or outline ahead of time	<input type="checkbox"/> Limit exposure to computer screens
<input type="checkbox"/> Extra time for testing or testing across multiple sessions	<input type="checkbox"/> No tests or quizzes
<input type="checkbox"/> Access to a guidance counselor to develop a plan for missed work	

Student is cleared to return to full school activities without accommodations.

Thank you for your cooperation and support of this student during their recovery time.

Treating physician (signature): _____ MD / DO

Printed Name: _____ Address: _____

I, the parent, agree that the school may implement the accommodations identified here in.

Parent (signature): _____ Printed Name: _____