

## RETURN TO SCHOOL AFTER CONCUSSION

STUDENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ GRADE: \_\_\_\_\_

DATE OF CONCUSSION: \_\_\_\_\_

SCHOOL (please check school of attendance):

- |   |                   |  |                   |
|---|-------------------|--|-------------------|
| <input type="checkbox"/> White River High School    | Fax; 360-829-3351 | <input type="checkbox"/> Glacier Middle School | Fax; 360-829-3391 |
| <input type="checkbox"/> Elk Ridge Elementary       | Fax; 360-829-3392 | <input type="checkbox"/> Foothills Elementary  | Fax; 360-829-3381 |
| <input type="checkbox"/> Mountain Meadow Elementary | Fax; 360-829-3388 | <input type="checkbox"/> Wilkeson Elementary   | Fax; 360-829-3386 |

A concussion is a mild injury to the brain that temporarily changes how the brain normally works. It is usually caused by a sudden blow or jolt to the head, although children often bump or hit their heads without getting concussions. Signs and symptoms of a concussion include dizziness, headache, vomiting, confusion, acting dazed, forgetting what happened before or after the injury, and being "knocked out". A person does NOT need to be knocked out or lose consciousness to have had a concussion. Other words or terms for a concussion include mild traumatic brain injury (mild TBI) and mild closed-head injury.

### This section to be filled out by Physician

Student may return to school on: \_\_\_\_\_

#### PHYSICAL ACTIVITY:

- Student is **FULLY** limited and can NOT participate in any activities  
 Student is **PARTIALLY** limited and can participate in the following activities only:

- YES, student can return to RECESS and PE activities  
 Student has NO limitations and can return to full participation

#### ACADEMIC ACTIVITY:

- Student may return to full participation without limitations  
 The following cognitive accommodations are recommended for this student:
- Gradual re-integration to school (e.g., student returns part-time before resuming a full schedule)
  - Student not asked to do all missed work
  - Rest time or breaks as needed during the day
  - Overall homework and class work load reduced
  - No use of computer or other video equipment until after: \_\_\_\_\_ (DATE)
  - No testing until after: \_\_\_\_\_ (DATE)
  - Other: \_\_\_\_\_

Student has been counseled on how to self-manage this concussion:  Yes  No

Student may resume full participation in all activities after \_\_\_\_\_ (DATE)

Student is to be reevaluated on \_\_\_\_\_ (DATE) and may **NOT** resume full participation until cleared

Health care provider comments: \_\_\_\_\_

_____ Health Care Provider's Signature	_____ Telephone	_____ FAX
_____ Health Care Provider's Printed Name or Stamp	_____ Date	