

Clovis Unified School District

RETURN TO LEARN

Concussion School Care Plan – MUST be completed by student’s physician

This form is adapted from the Acute Concussion Evaluation (ACE) care plan on the CDC web site (www.cdc.gov/injury). All medical providers are encouraged to review this site if they have questions regarding the latest information on the evaluation and care of the scholastic athlete following a concussion injury.

Student Name: _____ Date of Birth: _____

Date of Injury: _____ Date of Evaluation: _____

The above student requires the following short term academic supports for proper concussion management in school (check all items that apply):

- Initial evaluation reveals no evidence of a concussion. Cleared for full academic and athletic activities.**

- Student does have a concussion.**
 - No School or school academic activities at this time.
 - Student may return to school with a reduced academic workload and **NO athletic activities**. (Check all appropriate academic restrictions that apply):
 - Shortened day - Recommend _____ hours per day or as tolerated.
 - Shortened classes (i.e., rest breaks during classes).
 - Maximum class length: _____ minutes or as tolerated.
 - Allow extra time to complete coursework/assignments and tests.
 - Allow 4-6 weeks to make-up any missing assignments or tests, and some assignments need to be forgiven (consult with counselor as necessary).
 - Lessen homework load by _____ %.
 - Maximum length of nightly homework: _____ minutes or as tolerated.
 - No classroom or standardized testing at this time.
 - Take rest breaks during the day as needed.
 - Student needs to be allowed to leave the classroom if symptoms are developing or worsening and he/she needs a quiet place to rest (like the nurse’s office). If symptoms do not improve, he/she needs to go home.
- Concussion resolved. Student is cleared for full academic participation, allowing 4-6 weeks to make-up any missed work. Student is monitoring self for relapsing symptoms.**
- Student is cleared to begin the Return to Play Protocol, but if the symptoms return, stop the protocol and follow up with your primary care provider.**

- Prolonged Symptoms/Illness: Request meeting of 504 or School Management. 504 team to discuss plan and necessary academic supports.**

Date of Next Evaluation: _____

Medical Office Information (Please Print/Stamp)

Physician Name: _____

Physician Signature: _____

Physician Office Phone: _____

Office Address: _____