Macomb School District Post-Concussion Evaluation Form

Patient Name:_____ Date of Evaluation:_____

Follow-up evaluation and revision of recommendations to occur on: _____

Academic Accommodations for Concussion Recovery

Based on today's evaluation, this student was diagnosed with a concussion. The following academic accommodations may help in reducing the cognitive load, thereby minimizing post-concussion symptoms and allowing the student to better participate in the academic process during the injury period. **These academic accommodations are recommended as part of medical care and treatment for this medical condition.** The student and parent are encouraged to discuss and establish accommodations with the school on a class-by-class basis. The school and parent may wish to formalize accommodations through a 504 Plan if symptoms persist following treatment and less formalized accommodations.

Attendance Restrictions: *Full/Partial days missed due to concussion symptoms should be medically excused.*

- ☐ No school attendance until_____
- ☐ Modified school attendance days per return to learn protocol then full days
- ☐ Full Days

Physical Activity:

- ☐ No PE Class/No sports participation as per protocol
- ☐ Begin return to play protocol when asymptomatic

☐ **Education accommodations as needed (examples listed below)**

Testing: *Students with a concussion have increased memory and attention problems. Highly demanding activities like testing can significantly raise symptoms (e.g. headache, fatigue) which in turn can make testing more difficult.*

Workload reduction: *It takes a concussed student much longer to complete assignments. Therefore, it is recommended that "thinking" or cognitive load be reduced, just as physical exertion is reduced.*

☐ **Prognosis:** Based on today's evaluation, this student is at risk for prolonged recovery.

Other Accommodations:

- ☐ Allow student to wear hat and /or sunglasses when outside of building (i.e. PE) due to sensitivity to light
- ☐ Report any changes in mood/personality
- ☐ Change setting (brightness/contrast) on computer screen
- ☐ Avoid busy environments (e/g/ leave class early to avoid hallway, cafeteria, assemblies)
- ☐ Other:_____

Physician/Athletic Trainer Signature:_____Date:_____

BOTH SIDES OF THIS FORM MUST BE COMPLETED

IHSA/IESA Post-concussion Consent Form (RTP/RTL)

Date: _____

Student's Name: _____ **Year in School 7 8 9 10 11 12**

By signing below, I acknowledge the following:

1. I have been informed concerning and consent to my student's participating in returning to play in accordance with the return-to-play and return-to-learn protocols established by Illinois State law;

2. I understand the risks associated with my student returning to play and returning to learn and will comply with any ongoing requirements in the return-to-play and return-to-learn protocols established by Illinois State law;

3. And I consent to the disclosure to appropriate persons, consistent with the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), of the treating physician's or athletic trainer's written statement, and, if any, the return-to-play and return-to-learn recommendations of the treating physician or the athletic trainer, as the case may be.

Student's Signature: _____

Parent/Guardian's Name: _____

Parent/Guardian's Signature: _____

For School Use only

Written statement is included with this consent from treating physician or athletic trainer working under the supervision of a physician that indicates, in the individual's professional judgement, it is safe for the student to return-to-play and return-to-learn.

Cleared for RTL **Cleared for RTP**

Date: _____ Date: _____