

CONCUSSION HEALTH CARE PLAN

Please bring or mail this health care plan to the school

Student: _____ **Birth Date:** _____ **School Year:** _____

School: _____ **Homeroom Teacher:** _____ **Grade/Team:** _____

Date Concussion occurred: _____ **Date Child May Return to School:** _____

Activity restrictions (*review physical exertion below*) Cleared for full activity

Please allow the following recommendations from date _____ through date _____

<p>Attendance</p> <p><input type="checkbox"/> No school for _____ school day(s)</p> <p><input type="checkbox"/> No school until symptom free or significant decrease in symptoms</p> <p><input type="checkbox"/> Part time attendance for _____ days as tolerated</p> <p><input type="checkbox"/> Full school days as tolerated</p> <p><input type="checkbox"/> Other _____</p> <p>Visual/ Light Sensitivity</p> <p><input type="checkbox"/> Allow to wear sunglasses in school</p> <p><input type="checkbox"/> Allow access to darkened area to rest for _____ minutes</p> <p><input type="checkbox"/> Contact parent to go home if symptoms do not subside</p> <p><input type="checkbox"/> Other _____</p> <p>Auditory Sensitivity</p> <p><input type="checkbox"/> Allow to leave class 5 min early to avoid noisy hallways</p> <p><input type="checkbox"/> Lunch in a quiet place</p> <p><input type="checkbox"/> Allow access to quiet area to rest for _____ minutes</p> <p><input type="checkbox"/> Contact parent to go home if symptoms do not subside</p> <p><input type="checkbox"/> Other _____</p>	<p>Physical Exertion</p> <p><input type="checkbox"/> No physical exertion/athletics/gym/after school activities</p> <p><input type="checkbox"/> No recess</p> <p><input type="checkbox"/> Light aerobic activities only</p> <p><input type="checkbox"/> Non-contact/non-collision activities only</p> <p><input type="checkbox"/> Begin return to play protocol prior to returning to gym, athletics, after school activities</p> <p><input type="checkbox"/> Allow return to after school activities as observer only</p> <p><input type="checkbox"/> Allow return to after school activities as participant</p> <p><input type="checkbox"/> No restrictions for physical exertion/athletics/gym/after school activities</p> <p>Breaks</p> <p><input type="checkbox"/> Allow access to nurse's office if symptoms persist</p> <p><input type="checkbox"/> Allow access to increased water intake</p> <p><input type="checkbox"/> Allow access to restroom if increased water intake</p> <p><input type="checkbox"/> Other _____</p> <p>Additional Recommendations:</p>
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Current Symptom List

<input type="checkbox"/> Headache <input type="checkbox"/> Difficulty concentrating <input type="checkbox"/> Sensitivity to light <input type="checkbox"/> Trouble falling asleep <input type="checkbox"/> Visual problems	<input type="checkbox"/> Difficulty remembering <input type="checkbox"/> Sensitivity to noise <input type="checkbox"/> Drowsiness <input type="checkbox"/> Dizziness <input type="checkbox"/> Feeling slowed down	<input type="checkbox"/> Feeling more emotional <input type="checkbox"/> Sleeping less than usual <input type="checkbox"/> Nausea <input type="checkbox"/> Feeling mentally foggy <input type="checkbox"/> Irritability	<input type="checkbox"/> Sleeping more than usual <input type="checkbox"/> Fatigue <input type="checkbox"/> Balance problems
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PAIN MANAGEMENT:

Medication Name	Dosage (amount)/Time	When To Use	Given at School
			<input type="checkbox"/> YES <input type="checkbox"/> NO
			<input type="checkbox"/> YES <input type="checkbox"/> NO

► **Physician's Signature** ◀ _____ **Date:** _____

PRINT Physicians Name: _____ **Phone #:** _____

I, this child's parent/guardian, hereby authorize the named Healthcare Provider who has attended to my child, to furnish to the School Health Services Coordinator and/or School Clinic Staff any medical information and/or copies of records pertaining to my child's chronic health condition and for this information to be shared with pertinent school staff at my child's school. I understand that as of April 14, 2003, under the Health Insurance Portability and Accountability Act ("HIPAA") disclosure of certain medical information is limited. However, I expressly authorize disclosure of information so that my child's medical needs may be served while in attendance in the Fayette County Schools. This authorization expires as of the last day of the school year.

► **Parent/Guardian's Signature** ◀ _____ **Date:** _____