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: _____