SCHOOL LETTER

Returning to School After a Concussion

CDC HEADS UP
SAFE BRAIN. STRONGER FUTURE.

DEAR SCHOOL STAFF:

This letter offers input from a healthcare provider with experience in treating concussion, a type of traumatic brain injury. This letter was created to help school professionals and parents support students returning to school after a concussion. You can use these recommendations to make decisions about support for your student based on his or her specific needs. This letter is not intended to create a 504 Plan or an IEP unless school professionals determine that one is needed. Most students will only need short-term support as they recover from a concussion. A strong relationship between the healthcare provider, the school, and the parents will help your student recover and return to school.

_____ was seen for a concussion on _____
Student Name Date

in _____ office or clinic.
Healthcare Provider's Name

The student is currently reporting the following symptoms:

PHYSICAL

- ☐ Bothered by light or noise
- ☐ Dizziness or balance problems
- ☐ Feeling tired, no energy
- ☐ Headaches
- ☐ Nausea or vomiting
- ☐ Vision problems

THINKING OR REMEMBERING

- ☐ Attention or concentration problems
- ☐ Feeling slowed down
- ☐ Foggy or groggy
- ☐ Problems with short- or long-term memory
- ☐ Trouble thinking clearly

SOCIAL OR EMOTIONAL

- ☐ Anxiety or nervousness
- ☐ Irritability or easily angered
- ☐ Feeling more emotional
- ☐ Sadness

SLEEP

- ☐ Sleeping less than usual
- ☐ Sleeping more than usual
- ☐ Trouble falling asleep

The student also reported these symptoms:

_____

_____

_____

CDC

RETURNING TO SCHOOL

Based on the student's current symptoms, I recommend that the student:

☐ Be permitted to return to school and activities while school professionals closely monitor the student. School professionals should observe and check in with the student for the first two weeks, and note if symptoms worsen. If symptoms do not worsen during an activity, then this activity is OK for the student. If symptoms worsen, the student should cut back on time spent engaging in that activity, and may need some short-term support at school. Tell the student to update his or her teachers and school counselor if symptoms worsen.

☐ Is excused from school for _____ days.

☐ Return to school with the following changes until his or her symptoms improve.

(**NOTE:** Making short-term changes to a student's daily school activities can help him or her return to a regular routine more quickly. As the student begins to feel better, you can slowly remove these changes.)

Based on the student's symptoms, please make the short-term changes checked below:

☐ No physical activity during recess
☐ No physical education (PE) class
☐ No after school sports
☐ Shorten school day
☐ Later school start time
☐ Reduce the amount of homework
☐ Postpone classroom tests or standardized testing
☐ Provide extended time to complete school work, homework, or take tests
☐ Provide written notes for school lessons and assignments (when possible)
☐ Allow for a quiet place to take rest breaks throughout the day
☐ Lessen the amount of screen time for the student, such as on computers, tablets, etc.
☐ Give ibuprofen or acetaminophen to help with headaches (as needed)
☐ Allow the student to wear sunglasses, earplugs, or headphones if bothered by light or noise
☐ **Other:** _____

_____

✳ Anticipated End Date:_____

Most children with a concussion feel better within a couple of weeks. However, for some, symptoms can last for a month or longer. **If there are any symptoms that concern you, or are getting worse, notify the student's parents that the student should be seen by a healthcare provider as soon as possible.**

▸ For information on helping students return to school safely after a concussion, visit **www.cdc.gov/HEADSUP.**

_____ _____ _____

Healthcare Provider's Name (printed) | Healthcare Provider's Signature | Date

For additional questions, you may reach me at: _____

* form to complete when concussion is resolved

WASHINGTON INTERSCHOLASTIC ACTIVITIES ASSOCIATION

Return to Practice and Competition for Athletes with a Suspected Concussion

Youth Athlete Name_____ **D.O.B.:** _____

School/Organization:_____

Injury Date: _____ **Sport/Activity:** _____

Required Steps for Return to Practice and Competition: Initial each box that youth athlete has:

☐ Returned to baseline at rest for any concussion signs or symptoms

☐ Returned to all school and social activities (return to learn)

☐ Completed a multi-day medically supervised graduated return to play protocol

Was pre-season baseline neuropsychological testing completed? ☐ Yes ☐ No

If "Yes", who performed the baseline testing? _____

If "Yes", when was the baseline testing performed? _____

If "Yes", was post-injury neuropsychological testing completed? ☐ Yes ☐ No

A. If "Yes", who performed the post-injury testing? _____

B. When was the post-injury testing performed? _____

C. Did the post-injury testing return to pre-season baseline? ☐ Yes ☐ No

Meeting all of the above required and necessary steps for releasing a youth athlete for unrestricted return to practice and competition does not encompass all aspects of medical decision making for this injury. The healthcare provider must additionally consider many modifiers and situations unique to the youth athlete in making the clearance decision.

This youth athlete is cleared to return to full practice and play as of today.

Name of Licensed Healthcare Provider (MD, DO, ARNP, PA-C, LAT) *(Print)*: _____

Signature of Licensed Healthcare Provider:_____ Date:_____

Date of last youth athlete visit: _____

Contact number/email of Licensed Healthcare Provider: _____

I have reviewed the process documented above for this youth athlete to verify the required and necessary steps for unrestricted return to practice and competition have been completed.

Name of Athletic Director: _____

Signature of Athletic Director: _____

Date form signed by Athletic Director: _____