Nettle Creek School Corporation

# CONCUSSION HEALTH CARE PLAN

**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 _____

### Attendance
- ☐ No school for _____ school day(s)
- ☐ No school until symptom free or significant decrease in symptoms
- ☐ Part time attendance for _____ days as tolerated
- ☐ Full school days as tolerated
- ☐ Other _____

### Visual/ Light Sensitivity
- ☐ Allow to wear sunglasses in school
- ☐ Allow access to darkened area to rest for _____ minutes
- ☐ Contact parent to go home if symptoms do not subside
- ☐ Other _____

### Auditory Sensitivity
- ☐ Allow to leave class 5 min early to avoid noisy hallways
- ☐ Lunch in a quiet place
- ☐ Allow access to quiet area to rest for _____ minutes
- ☐ Contact parent to go home if symptoms do not subside
- ☐ Other _____

### Physical Exertion
- ☐ No physical exertion/athletics/gym/after school activities
- ☐ No recess
- ☐ Light aerobic activities only
- ☐ Non-contact/non-collision activities only
- ☐ Begin return to play protocol prior to returning to gym, athletics, after school activities
- ☐ Allow return to after school activities as observer only
- ☐ Allow return to after school activities as participant
- ☐ No restrictions for physical exertion/athletics/gym/after school activities

### Breaks
- ☐ Allow access to nurse's office if symptoms persist
- ☐ Allow access to increased water intake
- ☐ Allow access to restroom if increased water intake
- ☐ Other _____

### Additional Recommendations:

### Current Symptom List

| | | | |
|---|---|---|---|
| ☐ Headache | ☐ Difficulty remembering | ☐ Feeling more emotional | ☐ Sleeping more than usual |
| ☐ Difficulty concentrating | ☐ Sensitivity to noise | ☐ Sleeping less than usual | ☐ Fatigue |
| ☐ Sensitivity to light | ☐ Drowsiness | ☐ Nausea | ☐ Balance problems |
| ☐ Trouble falling asleep | ☐ Dizziness | ☐ Feeling mentally foggy | |
| ☐ Visual problems | ☐ Feeling slowed down | ☐ Irritability | |

### PAIN MANAGEMENT:

| *Medication Name* | *Dosage (amount)/Time* | *When To Use* | *Given at School* |
|---|---|---|---|
| | | | ☐ YES ☐ NO |
| | | | ☐ YES ☐ NO |

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

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

**PARENT/GUARDIAN SIGNATURE:** _____ **DATE:** _____

**SCHOOL NURSE SIGNATURE:** _____ **DATE:** _____