Concussion Plan

PALO ALTO UNIFIED SCHOOL DISTRICT
25 CHURCHILL AVENUE PALO ALTO, CA 94306
HEALTH SERVICES 650-833-4240 Fax 650-833-4226

DATE: _____

SCHOOL: _____

SCHOOL FAX: _____

STUDENT NAME: _____ **DOB:** _____

REFERRING STAFF: Name/Position

#1_____ Phone_____ Fax_____

#2_____ Phone_____ Fax_____

PARENT: I CONSENT to communication and exchange of information between referring staff and doctors: *(Ed Code 49423)*

Dr. _____Phone _____Fax _____

Dr. _____Phone _____Fax _____

Parent/Guardian Signature:_____ Contact Number_____ Date:_____

HEALTH CARE PROVIDER REPORT

☐ It is my professional opinion the above named student **DID NOT** sustain a concussion and is medically released to return to school and all activities without restrictions.

Parent/Guardian must bring the signed concussion plan to school.

Physician Signature: _____Date: _____

Parent/Guardian Signature: _____Date: _____

☐ After reviewing the available medical facts, it is my professional opinion the above named student **DID** sustain a concussion on _____(date). **Physician to complete the following as below:**

The following symptoms may be present: CIRCLE ALL THAT APPLY **OR** **No reported symptoms**

Physical		Thinking	Emotional	Sleep
Headaches/Pressure in head	Sensitivity to light	Feeling mentally foggy, slowed down, hazy	Irritability	Drowsiness
Nausea	Sensitivity to noise	Problems concentrating or remembering	Sadness	Sleeping more than usual
Fatigue	Numbness/Tingling		Feeling more emotional	Sleeping less than usual
Visual disturbances	Vomiting		Nervousness	Trouble falling asleep
Balance Problems	Dizziness			
Other				

RETURNING TO SCHOOL: Duration of Recommendations ☐ 1 week ☐ 2 weeks ☐ 4 weeks ☐ Until (Date)_____

The following are recommended: *(check all that apply)*

☐ **Return to school without restriction**

☐ **No return to school for _____ days. Return (Date)_____.**

☐ Student is NOT able to do home/schoolwork during this time.

☐ Student may do home/schoolwork for total of _____ minutes per day if no symptoms present.

☐ **Return to school with following recommendation/s.**

☐ Shortened day. Recommend _____ hours per day.

☐ Shortened classes (i.e. rest breaks during classes). Maximum class length: _____ minutes.

☐ Allow extra time to complete coursework/assignments and tests.

☐ Student may do homework for a total of _____ minutes per day

☐ No classroom or standardized testing at this time.

☐ Take rest breaks during the day as needed in health office.

Decrease visual and auditory stimulation as needed by the student (e.g., reduction of monitor brightness, limitation of screen time and music exposure, provision of a quiet lunch space, permission to wear sunglasses, brimmed hats or earplugs)

If symptoms worsen or persist despite these measures for more than two weeks, student should return to their health care provider for further evaluation. Parent will inform school in writing of any updated recommendations from their health care provider.

RETURNING TO PE/SPORTS/PLAY

It is important to ensure each child has a full and complete recovery from his or her concussion. As with schoolwork, a **gradual** return to play/PE/sports is strongly recommended for optimal safety and is based on current concussion management guidelines. ***Before returning to full contact sports play, all students must be cleared by their physician (CEC 49475.)***

Student's PE Care Plan:

Do NOT return to PE until *(date required)* _____

Return to PE modified with walking only until *(date required)* _____

Return to PE fully *(date required)* _____

Do NOT return to Sports/Practices/Games until *(date required)* *_____

VERY IMPORTANT #1: There should be at least 24 hours between each stage. Student may not progress to the next stage until symptom free for 24 hours. If concussion symptoms return at any stage, student needs to start all over again at Stage 1.

VERY IMPORTANT #2: All athletes must be seen by a physician after they have progressed through Stage 4 to be cleared to return to full contact game play. (CEC 49475)

Stage 1	No physical activity.
Stage 2	Low levels of physical activity. This includes walking, light jogging, light stationary biking, light weight lifting (lower weight, higher rep, no bench and no squat).
Stage 3	Moderate levels of physical activity with body/head movement. This includes moderate jogging, brief running, moderate-intensity stationary biking, moderate-intensity weightlifting (reduced time and/or reduced weight from typical routine)
Stage 4	Heavy non-contact physical activity. This includes sprinting/running, high-intensity stationary biking, regular weightlifting routine, non-contact sport-specific drills (in 3 planes of movement) **Return to physician for full clearance once doing well at Stage 4. *Provide physician clearance to coach/school (CEC 49475)***
Stage 5	Full contact in controlled practice (AAP guideline recommends that patient should be back at academic baseline before return to full play)
Stage 6	Full contact in game play – requires clearance by physician

Physician Information

Physician Name: (Print)_____ Physician Signature: _____

Office Telephone number: _____ Date: _____

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Parent/Guardian Information

Parent/Guardian must bring a concussion form signed by a doctor to both their student's school office and to their student's coach.

Parent/Guardian Name: (Print) _____ Parent Signature: _____

Parent/Guardian contact number: _____ Date: _____

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Distribution: Health Clerk/Tech Counselor PE Teacher Teacher District Nurse Cum File