

Riverview School District  
**RETURN TO SCHOOL AFTER CONCUSSION**

**STUDENT NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**SCHOOL:** \_\_\_\_\_ **GRADE:** \_\_\_\_\_

**DATE OF CONCUSSION:** \_\_\_\_\_

A concussion is a mild injury to the brain that temporarily changes how the brain normally works. It is usually caused by a sudden blow or jolt to the head, although children often bump or hit their heads without getting concussions. Signs and symptoms of a concussion include dizziness, headache, vomiting, confusion, acting dazed, forgetting what happened before or after the injury, and being "knocked out." A person does NOT need to be knocked out or lose consciousness to have had a concussion. Other words or terms for a concussion include mild traumatic brain injury (mild TBI) and mild closed-head injury.

**Student may return to school on** \_\_\_\_\_  
(DATE)

**PHYSICAL ACTIVITY:**

- Student is **FULLY** limited and can NOT participate in any activities
- Student is **PARTIALLY** limited and can participate in the following activities only: \_\_\_\_\_  
\_\_\_\_\_
- YES, Student can return to RECESS and PE activities
- Student has **NO** limitations and can return to full participation

**ACADEMIC ACTIVITY:**

- Student may return to full participation without limitations.
- The following cognitive accommodations are recommended for this student:
  - Gradual re-integration to school (e.g., student returns part-time before resuming a full schedule)
  - Student not asked to do all missed work
  - Rest time or breaks as needed during the day
  - Overall homework and class work load reduced
  - No use of computer or other video equipment until after \_\_\_\_\_ (DATE)
  - No testing until after \_\_\_\_\_ (DATE)
  - Other: \_\_\_\_\_

Student has been counseled on how to self-manage this concussion:  YES  NO

**Student may resume full participation in all activities after** \_\_\_\_\_ (DATE)

**Student is to be re-evaluated on** \_\_\_\_\_ (DATE) **and may NOT resume full participation until cleared.**

Health care provider comments:

\_\_\_\_\_  
Health Care Provider's Signature Telephone Fax

\_\_\_\_\_  
Health Care Provider's Printed Name or Stamp Date

**Routing:**

Parent	Nurse	Counselor	Teacher	PE	Principal	Coach	
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