CLAYTON
HIGH SCHOOL

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#1 Mark Twain Circle Clayton, Missouri 63105-1613
(314) 854-6612 Fax (314) 854-6734

RECOMMENDED ACCOMMODATIONS FOR A CONCUSSION

Patient Name_____ **Date of Birth** _____

Date of Evaluation_____

Physician Diagnosis _____

It is recommended that the following guidelines be implemented to minimize symptoms and avoid lengthening the recovery of the patient.

Duration of Recommendations - days/weeks_____

PLEASE NOTE: The student will need to provide either a note of clearance or a new set of recommendations from the physician when the period of recommendation is complete.

Please consider the academic accommodations listed below.
Initial ALL that apply:

I. Attendance Accommodations

- ___ Full school days OK
- ___ No school for _____ day(s)
- ___ Part-time attendance for _____day(s)
- ___ Allow student to go to nurse office if symptoms increase

II. Sensory Accommodations

- ___ Allow student to wear sunglasses if needed
- ___ Limited computer, TV, bright screen use
- ___ Allow to wear earplugs as needed
- ___ Avoid extracurricular activities (bright lights, loud areas)
- ___ Avoid sporting events/athletic contests (areas of potential re-injury)
- ___ Lunch in quiet place if needed
- ___ Avoid music classes or loud areas

III. Workload Accommodations

- ___ Copies of class notes
- ___ Reduce overall amount of homework
- ___ No testing or homework for ____day(s)
- ___ Limit homework to ___ minutes/night/class
- ___ Extra time to complete tests
- ___ No more than one test a day
- ___ No Standardized testing

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IV. Physical Accommodations

☐ No physical exertion/athletic/gym

V. Additional Accommodations_____

Current Symptoms List (the patient is complaining of at time of doctor visit)

☐ Headache	☐ Difficulty concentrating	☐ Sensitivity to light
☐ Dizziness	☐ Visual problems	☐ Difficulty remembering
☐ Drowsiness	☐ Sensitive to noise	☐ Feeling Foggy
☐ Nausea	☐ Balance problems	☐ Irritability

The patient will be reassessed for revision of these recommendations on _____.
Date

_____ _____
Physician Signature **Date**

Notes from the School Nurse

_____
_____
_____

_____ _____
Nurse Signature **Date**

PLEASE NOTE
The academic recommendation form MUST be completed by the physician in order to receive accommodations. These accommodations will NO LONGER be valid once the student is released to return to play or is released from the care of their physician.