HARVESTCHRISTIANACADEMY
CONCUSSION CARE PLAN

Student Name: _____**Date:** _____ **Date of Injury:** _____

RED FLAGS			
Headaches that worsen	Look very drowsy, can't be awakened	Can't recognize people or places	Unusual behavior change
Seizures	Repeated vomiting	Increasing confusion	Increasing irritability
Neck pain	Slurred speech	Weakness or numbness in arms or legs	Loss of consciousness

__ Call parent if any above symptoms are noticed

__ Call the doctor if any above symptoms are noticed

Today the following symptoms are present (circle or check)

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

__ No reported symptoms

__ No return to school

__ Return to school on _____

__ Return to school with following supports (see page 2)

__ Review on _____

__ Concussion resolved. Cleared for full academic participation and may resume all athletic activities without restrictions.

See side 2 for more instructions

DAILY CONCUSSION MANAGEMENT PLAN

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

__ Shortened day. Recommend ___ hours per day until _____

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

__ Homework: Maximum length of nightly homework: _____ minutes.

__ Take rest breaks during the day as needed.

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

__ Classroom focused attending time limited to _____minutes per class

__ No standardized testing; allow verbal tests no longer than _____minutes

May be adjusted weekly by school nurse as long as symptoms do not occur

__ Request meeting of 504 or School Management Team to discuss this plan and needed supports.

__ Do not return to PE class at this time per doctor's order

__ Do not return to sports practices/games at this time per doctor's order

Staff to watch for: (send to the nurse if these symptoms are noticed)

- Increased problems paying attention or concentrating
- Increased problems remembering or learning new information
- Longer time needed to complete tasks or assignments
- Greater irritability, less able to cope with stress
- Symptoms worsen (e.g., headache, tiredness) when doing schoolwork.

AUTHORIZATIONS

_____ may take _____

Medication name dose frequency

Physician's Name _____ Office phone _____

Physician's signature: _____

- I assume responsibility for supplying medication to the school that will not expire during the course of its intended use. *Expired medication cannot be administered.*
- I understand that medication must be in its original container.
- I request this medication be administered as ordered by the students' licensed health care provider.
- I understand that this medical information may be shared with school staff working with my child.

Parent's signature: _____

This form adapted from "Heads UP: Brain injury in your practice" tool kit developed by the Centers for Disease Control and Prevention (CDC).