### HARVEST CHRISTIAN ACADEMY
### CONCUSSION CARE PLAN

**Student Name:** ___________________________  **Date:** ______  **Date of Injury:** ______

**RED FLAGS**

<table>
<thead>
<tr>
<th>Physical Symptoms</th>
<th>Thinking Symptoms</th>
<th>Emotional Symptoms</th>
<th>Sleep Symptoms</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headaches</td>
<td>Sensitivity to light</td>
<td>Feeling mentally foggy</td>
<td>Irritability</td>
</tr>
<tr>
<td>Nausea</td>
<td>Sensitivity to noise</td>
<td>Problems concentrating</td>
<td>Sadness</td>
</tr>
<tr>
<td>Fatigue</td>
<td>Numbness/Tingling</td>
<td>Problems remembering</td>
<td>Feeling more emotional</td>
</tr>
<tr>
<td>Visual problems</td>
<td>Vomiting</td>
<td>Feeling more slowed down</td>
<td>Nervousness</td>
</tr>
<tr>
<td>Balance Problems</td>
<td>Dizziness</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Today the following symptoms are present (circle or check)**

- __ Call parent if any above symptoms are noticed
- __ Call the doctor if any above symptoms are noticed

- __ 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
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

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

<table>
<thead>
<tr>
<th>Medication name</th>
<th>dose</th>
<th>frequency</th>
</tr>
</thead>
</table>

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).