Acute Concussion Short Term Care

To be completed by student's Physician/Nurse Practitioner/Physician Assistant **adapted from NYSSHSC/Revised 5/2019**

Student Name _____ Date of Birth _____ Grade _____

Date of Injury _____Sport/Activity_____ School_____

Expected Date of Return to School _____ **CONCUSSION DIAGNOSED By Doctor YES or NO**

The above student has been identified as symptomatic consistent with an acute concussion. The academic planning team *may need to consider* the following *short term academic supports* for proper concussion management in school (checked items apply). Implementation will be determined by the academic planning team:

- ❑ **No specific educational modifications are indicated (Return to Learn)**
- ❑ Shortened day or modified schedule as determined
- ❑ Extra time to complete coursework, assignments, tests or modified tasks in the classroom
- ❑ Limits to number of tests required within a single school day _____
- ❑ No test
- ❑ Limit or modify homework requirements to allow adequate cognitive rest time _____
- ❑ No homework
- ❑ Headaches occurring post-concussive incident would indicate that the student should not be driving and symptom related school dismissal will require parent transport
- ❑ No outdoor or indoor running or active contact play
- ❑ Limit screen time or technology use to_____minutes/hours
- ❑ No Screen time

The above student should adhere to the following recommendations regarding physical education (PE) and athletic participation (checked items apply):

- ❑ Is medically cleared to participate in Physical Education (PE) within the school program
- ❑ Is medically cleared to participate in sports/athletics
- ❑ May not return to PE until further notice
- ❑ May not return to sports/athletics until further notice
- ❑ May gradually return* to physical activity under the supervision of an appropriate person (e.g. athletic trainer, coach or physical education teacher). *Return to play should occur in gradual steps as listed below:

1. Begin with aerobic exercise only to increase heart rate (walking, light jogging, and stationary cycling, light weight lifting – low weight, higher reps, no bench, no squat)
2. Work to increase heart rate with body/head movement (jogging, brief running, moderate intensity stationary biking, moderate intensity weightlifting – reduced time and reduced weight from typical routine)
3. Move on to heavy non-contact physical activity (sprinting/running, high intensity stationary biking, regular weightlifting routine, non-contact sport specific drills (in 3 planes of movement)
4. Return to full contact in controlled practice (before return to full contact in game play).
5. Return to full contact in game play on or after _____

*Students: pay careful attention to your symptoms, including thinking and concentration skills, at each stage of activity. You should only move on to the next level of activity when you do not experience any symptoms during or after the activity for 2-3 days at the current level. If symptoms do return, please contact me for further medical advice.

<u>If Diagnosed</u> these recommendations will be reviewed and updated on _____

<u>Physician follow up is necessary to retain academic accommodations</u>. <u>Return this completed Form to the School Nurse</u>

Health Care Provider Signature _____ Date _____
Printed Name _____ Telephone _____ Fax _____

Bedford County Public Schools

310 South Bridge Street, Bedford, VA 24523
Phone (540) 586-1045

AUTHORIZATION FOR CONFIDENTIAL RELEASE AND EXCHANGE OF EDUCATION AND HEALTH RECORDS

LEGAL FULL NAME OF STUDENT/PATIENT	STUDENT/PATIENT DATE OF BIRTH

SCHOOL/AGENCY/PERSON RELEASING RECORDS	ADDRESS	PHONE NUMBER	FAX NUMBER

OFFICIAL REQUESTING RECORDS/TITLE	ADDRESS	PHONE NUMBER	FAX NUMBER

I request release or exchange of the following information on my child or ward to the official stated above for the purpose of:

_____.

✓ CHECK ALL THAT APPLY

□ Official Scholastic Record (includes: student name/address, parent's names/addresses, certified copy of birth Certificate (Code of Virginia § 22.1-3.1C) or birth certificate number as recorded by another VA public school, birth date, grade level completed, class standing, attendance record, Student Testing Identifier (STI), extracurricular activities, citizenship, if other than the United States, etc.)

□ Scholastic grades (historical and withdrawal grades with grading scale) □ Discipline Record

□ Group and individual intelligence, achievement, aptitude and interest test scores (includes: SOL, AP, PSAT, SAT, ACT, Stanford 10, Olsat, Naglieri, etc)

□ Limited English Proficiency (LEP) records □ Talented and Gifted (TAG) records

□ 504 records, Individualized Education Program (IEP), latest eligibility minutes, eligibility summary, SCT information, evaluation reports and functional behavioral assessments.

□ All heath records listed below

□ Physical and immunization records with dates signed by doctor or school nurse □ Lab reports
□ Medical diagnosis □ Doctor's orders □ Medical Care Plan □ Mental/ Health/Psychiatric
□ Discharge Summary □ Audiological/Vision □ Speech Reports □ Social / Cultural
□ Psychological Reports □ Fitness data

□ Others (please specify): _____
_____
_____

This authorization is valid for one year unless specified otherwise. It will expire on _____
I understand that I may withdraw this authorization by submitting written notice to the school/agency/person releasing records stated above. I understand that health records, once received by the school district, may no longer be protected by HIPPA, but they will become education records protect by the Family Educational Rights and Privacy Act (FERPA). I have the right to request a hearing to challenge the content and accuracy of these records on the student/patient named above.

_____ _____
SIGNATURE OF PARENT/GUARDIAN/LEGAL CUSTODIAN OR ELIGIBLE STUDENT DATE

_____
SIGNATURE OF SCHOOL OFFICIAL COMPLETING