



Mild TBI/Concussion Temporary Accommodations Plan

These are recommendations and over time may need to be adjusted through the school Concussion Management Team. If any questions or concerns please call your provider.

Patient name: _____

Date: _____

Current symptoms: Headaches Difficulty remembering Sensitivity to light Fatigue Decreased attention

Other: _____

Physician Name: _____ Phone: _____ Physician Signature: _____

The patient will be reevaluated for revision of these recommendations in _____ weeks.

Date: _____

These Are Initial Recommendations These Are Follow-Up Recommendations

Area	Requested Accommodations	Comments/ Clarifications
Attendance	<input type="checkbox"/> No School until _____ <input type="checkbox"/> Partial School day as tolerated by student <input type="checkbox"/> Full school day as tolerated by student	
Breaks	<input type="checkbox"/> If symptoms appear/worsen, allow student to go to quiet area or nurse's office; if no improvement after 30 min allow dismissal to home <input type="checkbox"/> Water bottle in class / snack every 3-4 hours as needed <input type="checkbox"/> Allow breaks during the day as needed by student or school personnel	
Visual Stimulus	<input type="checkbox"/> Limit iPad use <input type="checkbox"/> Limited computer, TV screen, bright screen use <input type="checkbox"/> Allow handwritten assignments or more instructions for homework <input type="checkbox"/> Allow student to wear sunglasses/hat in school, seat student away from windows and bright lights <input type="checkbox"/> Change classroom seating to front of room as necessary	
Auditory Stimulus	<input type="checkbox"/> Avoid loud classroom activities and/or classes (i.e. band, shop, choir) <input type="checkbox"/> Lunch in a quiet place with a friend <input type="checkbox"/> Allow student to wear earplugs as needed <input type="checkbox"/> Allow class transitions before bell	
School Work	<input type="checkbox"/> Simplify tasks <input type="checkbox"/> Reduce overall amount of in-class work or homework to essentials. <input type="checkbox"/> No homework <input type="checkbox"/> Extra tutoring/assistance requested <input type="checkbox"/> May begin make-up of essential work (critical tasks only, consider alternative ways for student to demonstrate knowledge) <input type="checkbox"/> Provide extended time to complete assignments and/or shortened assignments	
Testing	<input type="checkbox"/> No or limited testing during recovery periods (midterms, finals, standardized, unit tests) until student is cleared. <input type="checkbox"/> Additional time/untimed testing <input type="checkbox"/> No more than one test a day <input type="checkbox"/> Provide extended time to take tests in a quiet environment (do not mark if student is deferred from test taking)	
Emotional Development Plan	<input type="checkbox"/> Develop an emotional support plan for the student (may include an adult with whom the student can talk, if feeling overwhelmed)	
Physical Activity	<input type="checkbox"/> No physical exertion/athletics/gym/recess <input type="checkbox"/> Walking in PE/recess only <input type="checkbox"/> May begin return to play (see OSAA form)	
Extracurricular Activities	<input type="checkbox"/> Ok to participate in school dances <input type="checkbox"/> Ok to attend school/sporting events/field trips (Please specify) <input type="checkbox"/> Other (Please specify)	

Parents: Make sure to show this form to your concussion management team. Review weekly with RN or concussion management team. Your Concussion Management Team may consist of Athletic trainer, RN, educational supervisor and/or school counselor.