Pulaski County Public Schools

Traumatic Brain Injury/Post-Concussion Health Care Plan

Student Name: ____ DOB: __________ School: ___________

Medication Allergies: ____ School Year: _________________________

TO BE COMPLETED BY PHYSICIAN OR LICENSED PRESCRIBER

Date of Injury: ____________________ Cause of Injury: ____

Symptoms that are currently present (circle all that apply): ____No Reported Symptoms

Physical		**Thinking**	**Emotional**	**Sleep**
Headaches	Sensitivity to Light	Mentally Foggy	Irritability	Drowsiness
Nausea	Sensitivity to Noise	Problems concentrating	Sadness	Sleeping More
Vomiting	Numbness/Tingling	Problems Remembering	More emotional	Sleeping Less
Dizziness	Visual Problems	Feeling more slowed down	Nervousness	Trouble falling asleep
Balance Problems	Fatigue			

Red Flags: Call your Doctor or go to the emergency department if you suddenly experience any of the following			
Headaches that *worsen*	*Very* drowsy, can't be awakened	Can't *recognize* people or places	Weakness or numbness in arms/legs
Seizures	Repeated vomiting	Increasing confusion	Increasing irritability
Neck Pain	Slurred speech	Unusual behavior changes	Loss of consciousness

The following school restrictions, accommodations, and/or provisions are required at this time (Please check all that are needed):

_____ Student may ***not*** return to school _____ Student may return to school on (date): ______________

Student may return to school with the following accommodations (check all that apply):

_____ Partial or shortened school day – indicate number of hours recommended per day _____, until (date): _________

_____ Shortened class time – indicate length of class time recommended _____, until (date): __________

_____ Rest Breaks – indicate frequency of rest break intervals _____

_____ No regular academic testing

_____ Allow extra time for testing

_____ No standardized testing at this time

_____ Allow extra time to complete classwork

_____ Allow extra time to complete homework assignments and projects

_____ Ensure less homework by _____%

_____ Request 504 meeting to discuss this plan and needed supports

_____ Check for return of symptoms when doing activities that require a lot of attention or concentration

(Physician Use)

Student may return to school with the following activity restrictions or provisions (check all that apply):

_____ No PE class at this time

_____ No recess at this time or limited recess (state length of recess time): __________

_____ May return to PE for a limited time

Return to Play Criteria:

_____ No sports practices or games at this time

_____ Progressive return to play protocol that includes at least 24 hours of the following activities:

1. Rest until asymptomatic (physical and mental rest)
2. Light aerobic exercise
3. Sport-specific exercise
4. Non-contact training drills (start light resistance training)
5. Full contact training (after medical clearance)
6. Return to competition

Please provide any additional information, accommodations, or restrictions that are required for the above named student during the school day or as it relates to learning and school sponsored activities:

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Health Care Provider Signature: ____

Printed Name: ____

Date: ________________________ Phone Number: _____________________________

Parent/Guardian Signature: ____

Date: ____

(School Use Only)

Returning to Daily Activities

1. Get lots of rest. No late nights.
2. Drink lots of fluids and eat a well-balanced diet.
3. During recovery, it is normal to feel frustrated or sad when you do not feel normal or participate in activities as you normally would.
4. To help guide your plan of care, frequent evaluation of your symptoms is needed.
5. Avoid triggers such as: video gaming, prolonged computer use, television, phone use, texting, reading.

Returning to Sports Activities

1. You should never return to play if you are experiencing ANY symptoms. This includes while playing or at rest.
2. Returning to play should be gradual and closely monitored.

Symptoms for Teachers and Coaches to Monitor

1. Problems paying attention or concentrating
2. Difficulty remembering or learning new information
3. Increased Irritability
4. Headaches
5. Fatigue
6. Needing more time to complete tasks
7. Increased symptoms while doing school work
8. Pain
9. Emotional changes
10. Dizziness
11. Any changes from student's normal behavior

Notify School Nurse or Athletic Trainer Immediately for the Following:

1. Seizure
2. Repeated vomiting
3. Student can't <u>recognize</u> people or places
4. Loss of consciousness
5. Weakness or numbness in arms and legs
6. Slurred speech
7. Neck Pain
8. Headaches that <u>worsen</u>
9. Look <u>very</u> drowsy or can't be awakened
10. Increasing confusion

(School Use Only)

Plan for instructing administration, instructional staff, and coaches:

School nurse will share health care plan information with appropriate faculty and staff.

Plan for notifying substitutes:

Teacher is responsible to share health care plan information with substitutes.

I approve this TBI/Post Concussion Health Care Plan for my student. I give permission to share information about my child's condition with the school nurse, teachers, principals, guidance counselors, and coaches/trainers as appropriate.

Parent/Guardian Signature: ____Date: ____________

Parent/Guardian Printed Name: ____

Home Phone: ____________________ Cell Phone: ___________________ Work Phone: ______________

School Nurse Signature: _______________________________________ Date: _______________________

Health care plan information provided by _____________________________ to the following staff:

Name	Date	Name	Date

May 11, 2016