Pulaski County Public Schools
Traumatic Brain Injury/Post-Concussion Health Care Plan

Student Name: _____ DOB: _____ School: _____

Date of Injury: _____ Cause of Injury: _____

TO BE COMPLETED BY PHYSICIAN OR LICENSED PRESCRIBER

__ Fatigue	__ Headaches	__ Difficulty Remembering	__ Nervous	__ Trouble falling asleep
__ Vision Problems	__ Dizziness	__ Difficulty concentrating	__ Irritable	__ Sleeping More
__ Balance Issues	__ Vomiting	__ Mentally Foggy	__ More emotional	__ Sleeping Less
__ Sensitive to Noise	__ Nausea		__ Sad	__ Drowsy
__ Sensitive to Light				

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 (SOL Testing)

_____ Allow extra time to complete classwork

_____ Allow extra time to complete homework assignments and projects

_____ Ensure less school work by _____%

_____ Request 504 meeting to discuss this plan and needed supports

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

_____ No PE/Recess at this time

_____ May return to PE class. Return Date: _____

(Physician Use)

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:

_____

_____

_____

Parent Signature: _____ Date: _____

Health Care Provider Signature: _____ Date: _____

Printed Name: _____ Phone #: _____

Follow-up/Update to Care Plan Date: _____

_____
_____
_____

Follow-up/Update to Care Plan Date: _____

_____
_____
_____

Follow-up/Update to Care Plan Date: _____

_____
_____
_____

(School Use Only)

Returning to Daily Activities

1. Lots of rest is needed. No late nights.
2. Drink lots of fluids and eat a well-balanced diet.
3. Frustration and sadness can be normal when recovering from a concussion.
4. Avoid triggers such as: video gaming, prolonged computer use, television, phone use, texting, or reading.

Returning to Sports Activities

1. Never return to play/activity 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 recognize people or places
4. Loss of consciousness
5. Weakness or numbness in arms and legs
6. Slurred speech
7. Neck Pain
8. Headaches that worsen
9. Look very 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