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

Student's Name: _________________________ DOB: _________________ School: _________________

Medication Allergies: ____ School Year: _____________

TO BE COMPLETED BY PHYSICIAN OR LICENSED PRESCRIBER

Date of Injury: _________________

Symptoms that are currently present (circle all that apply): No symptoms are present at this time____

Thinking	Physical		Sleep	Emotional
Problem with concentration	Dizziness	Noise sensitivity	Interrupted sleep	Feeling sad
Trouble remembering	Headaches	Light sensitivity	Trouble falling asleep	Anxiety
Feeling unclear when thinking	Vomiting	Numbness	Sleeping more than normal	Nervousness
Thinking is slower than normal	Visual problems	Tingling	Sleeping less than normal	Irritability
Pain occurs when thinking	Issues with balance	Nausea		Feeling unsure
Problems learning new information	Fatigue			Feeling more emotional

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 ____

____ Shortened class time – indicate length of class time recommended ____

____ 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 assignment and projects

____ Ensure less homework by ____%

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) ___________

____ No sports, organizational sports, or recreational sports activity at this time

____ May return to PE for limited time (state how long per PE session) ______________

Gradual Return to Play Criteria (check all that apply):

____ Student may return to activity utilizing the following guidelines:

____ Low level of activity (circle all that apply): walking, light jogging, light stationary biking, no bench, no squat, light weight lifting, non-contact

____ Moderate activity (circle all that apply): moderate or brief running, moderate stationary biking, moderate intensity weight lifting (reduced time and weight)

____ Heavy non-contact (circle all that apply): running, sprinting, high intensity stationary biking, regular weight lifting, non-contact sport specific drills

____ Full contact in controlled practice

____ Full contact in game play

School personnel should watch for the following signs or symptoms and send student to the School Health Clinic for further assessment:

- Increased problems with paying attention or concentrating
- Confusion or dizziness
- Longer time needed to complete assignments and classwork
- Increased problems with learning or remembering new information
- Increase in irritability or coping
- Any worsening of symptoms such as pain, tiredness, headaches, confusion, emotional changes
- Any change or changes from student's normal pattern

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

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This health care referral plan is based on today's medical evaluation:

Care Plan Completed by: ______________________________________ MD, NP, PhD.

Date Care Plan Completed: ________________________

Plan for instructing administration and instructional staff:
School nurse will share health care plan information with administration and instructional 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 child. I give permission to share information about my child's condition with the school nurse, teachers, principals, office staff, guidance, bus driver/transportation and cafeteria manager as appropriate. I give the principal or his designee the authority to call the rescue squad or take my child to a hospital emergency room in case of emergency.

Parent/Guardian Signature ______________________________________Date ______________________

Parent/Guardian PRINTED Name :

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Home Phone _______________ Work Phone ______________________ Cell Phone ______________________

School Use:
Health care plan information provided by ____________________________________ to the following staff:

Names of Persons and Date	*Names of Persons and Date*