# Returning to School

# After Concussion:

# School Letter

Dear School Staff:

This letter offers input from a healthcare provider with experience in concussion to help school professionals and parents support students returning to school after a concussion. You can use these recommendations to make decisions about support for your student based on his or her specific needs. This letter is not intended to create a 504 Plan or IEP unless school professionals determine that one is needed. Most students will only need short-term support as they recover from a concussion. A strong relationship between the healthcare provider, the school, and the parents will help your student recover and return to school.

(Student name) \_\_\_\_\_\_\_\_\_\_\_\_ was seen for a concussion on (Date)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ in \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (write healthcare provider’s name) office/clinic.

**The student is currently reporting** **the symptoms circled below** following their injury:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **PHYSICAL** | | **THINKING/REMEMBERING** | **SOCIAL/EMOTIONAL** | **SLEEP** |
| Headaches | Visual problems | Foggy or groggy | Irritability/Easily Angered | Sleeping more than usual |
| Bothered by light  or noise | Dizziness/ Balance problems | Problems with short- or long-term memory | Anxiety/Nervousness | Sleeping less than usual |
| Nausea or vomiting | Fatigue/Tired | Feeling slowed down/Slowed processing speed | Sadness | Trouble falling asleep |
|  |  | Attention and/or concentration problems | Feeling more emotional |  |

Student also reported these symptoms:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Based on the student’s current symptoms, I recommend that the student:

* Is permitted to return to school and activities while school professionals closely monitor the student. School professionals should observe and check in with the student for the first two weeks and note if symptoms worsen. If symptoms do not worsen during an activity then this activity is OK for the student. If symptoms worsen, the student should cut back on how much he or she does that activity and may need some short term support at school. Tell the student to update his teachers and school counselor if symptoms get worse.
* Is excused from school for days.

* Return to school with the following changes until his/her symptoms improve. (NOTE: Making short-term changes to a student’s daily school activities can help him or her return to a regular routine more quickly. As the student begins to feel better, you can slowly remove these changes**.**) **Based on the student’s symptoms, please make the short-term changes checked below:**
  + No physical activity during recess
  + No physical education (PE) class
  + No after-school sports
  + Shorten school day
  + Later school start time
  + Reduce the amount of homework
  + Postpone classroom tests or standardized testing
  + Provide extended time to complete school work, homework, or take tests
  + Provide written notes for school lessons and assignments (when possible)
  + Allow for a quiet place to take rest breaks throughout the day
  + Lessen the amount of screen time for the student, such as computers, tablets, etc.
  + Give ibuprofen or acetaminophen to help with headache (as needed)
  + Allow the student to wear sunglasses, ear plugs or head phones if bothered by light or noise
  + Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Most children with a concussion feel better within a couple of weeks. However for some, symptoms will last for a month or longer. **If there are any symptoms that concern you or are getting worse, notify the student’s parents that the student should be seen by a healthcare provider as soon as possible.**

For more information on helping students to return to school safely after a concussion, please visit: [www.cdc.gov/HEADSUP](http://www.cdc.gov/HEADSUP).

Healthcare Provider Name (printed) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_

Healthcare Provider Signature Date

For additional questions you can reach me at:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_