SUSSEX COUNTY PUBLIC SCHOOLS

CONCUSSION HEALTH CARE PLAN

Please return this health care plan to your child's school nurse.

Student _____ **Date of Birth** _____ **School Year** _____
School _____ **Homeroom Teacher** _____ **Grade**_____
Date Concussion Occurred _____ **Date Child May Return to School** _____
☐ Activity Restrictions (*review physical exertion below*) ☐ Cleared for Full Activity
☐ Please allow the following recommendations from date _____through_____

Attendance

☐No School for _____ school day(s)

☐No School until symptom free or decrease in symptoms

☐Part time attendance for _____ days as tolerated

☐Full School days as tolerated

☐Other _____

Visual/Light Sensitivity

☐Allow to wear sunglasses in school

☐Allow access to darkened area to rest for _____ minutes

☐Contact parent to go home if symptoms do not subside

☐Other_____

Auditory Sensitivity

☐Allow to leave class 5 min early to avoid noisy hallways

☐Lunch in a quiet place

☐Allow access to quiet area to rest for _____ minutes

☐Contact parent to go home if symptoms do not subside

☐Other_____

Physical Exertion

☐No physical exertion/athletics/gym/after school activities

☐No recess

☐Light aerobic activities only

☐Non-contact/non-collision activities only

☐Begin return to play protocol prior to returning to gym, Athletics, after school activities

☐Allow return to after school activities as observer only

☐Allow return to after school activities as participant

☐No restrictions for physical exertion/athletics/gym/ After-school activities

Breaks

☐Allow access to nurse's office if symptoms persist

☐Allow access to increased water intake

☐Allow access to restroom if increased water intake

☐Other_____

Additional Recommendations:

Current Symptom List

☐Headache	☐visual problems	☐Dizziness	☐Nausea
☐Difficulty concentrating	☐Difficulty remembering	☐Feeling slowed down	☐Feeling mentally foggy
☐Sensitivity to light	☐Sensitivity to noise	☐Feeling more emotional	☐Irritability
☐Trouble falling asleep	☐Drowsiness	☐Sleeping less than usual	☐Sleeping more than usual
☐Fatigue	☐Balance problems	☐Other	☐Other

Pain Management

Medication Name	Dosage (amount)/Time	When to Use	Given at School
			☐Yes ☐No
			☐Yes ☐No

⇨***Physician's Signature*** _____ ***Date***_____
Print Physician's Name: _____ **Phone #** _____

I, this child's parent/guardian, authorize disclosure of information to be shared with pertinent school staff so that my child's medical needs may be served while in attendance in the Sussex County School District. This authorization expires as of the last day of the school year.

⇨ ***Parent/Guardian's Signature*** _____ ***Date***_____