

## EDUCATIONAL ACCOMODATIONS CHECKLIST FOR CONCUSSIONS

**Instructions for Parents & Guardians:** Fill out the checklist below together with your child's primary physician and return it to the school nurse or principal. This sheet will provide the school staff with proper educational accommodations to guarantee your child the quickest recovery possible.

Visit [http://www.cdc.gov/headsup/pdfs/schools/tbi\\_returning\\_to\\_school-a.pdf](http://www.cdc.gov/headsup/pdfs/schools/tbi_returning_to_school-a.pdf) for more 'Returning to School After a Concussion' resources.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

I, \_\_\_\_\_, give permission for my physician to share the following information with my child's school and for communication to occur between the school and my physician for changes to this plan. Parent Signature: \_\_\_\_\_

Physician Name and Contact Information: \_\_\_\_\_ Physician Signature: \_\_\_\_\_

The patient will be reevaluated for revision of these recommendations in \_\_\_\_\_ weeks. Date: \_\_\_\_\_

### Computerized Neurocognitive Testing

Baseline Testing                       Post-injury Testing                       ImPACT Passport ID #: \_\_\_\_\_

| Area                     | Requested Accomodations   | Comments/<br>Clarifications |
|--------------------------|---|-----------------------------|
| <b>Attendance</b>        | <input type="checkbox"/> No School<br><input type="checkbox"/> Partial School day as tolerated by student – emphasis on core subject work<br><u>Encouraged Classes:</u> _____<br><u>Discouraged Classes:</u> _____<br><input type="checkbox"/> Full School day as tolerated by student<br><input type="checkbox"/> Water bottle in class/snack every 3-4 hours  |                             |
| <b>Breaks</b>            | <input type="checkbox"/> If symptoms appear/ worsen during class, allow student to go to quiet area or nurse's office; if No improvement after 30 minutes allow dismissal to home<br><input type="checkbox"/> <u>Mandatory Breaks:</u> _____<br><input type="checkbox"/> Allow breaks during day as deemed necessary by student or teachers/school personnel  |                             |
| <b>Visual Stimulus</b>   | <input type="checkbox"/> Enlarged print (18 font) copies of textbook material / assignments<br><input type="checkbox"/> Pre-printed notes (18 font) or note taker for class material<br><input type="checkbox"/> Limited computer, TV screen, bright screen use<br><input type="checkbox"/> Allow handwritten assignments (as opposed to typed on a computer)<br><input type="checkbox"/> Allow student to wear sunglasses/hat in school; seat student away from windows and bright lights<br><input type="checkbox"/> Reduce brightness on monitors/screens<br><input type="checkbox"/> Change classroom seating to front of room as necessary   |                             |
| <b>Auditory Stimulus</b> | <input type="checkbox"/> Avoid loud classroom activities<br><input type="checkbox"/> Lunch in a quiet place with a friend<br><input type="checkbox"/> Avoid loud classes/places (i.e. music, band, choir, shop class, gym and cafeteria)<br><input type="checkbox"/> Allow student to wear earplugs as needed<br><input type="checkbox"/> Allow class transitions before the bell   |                             |
| <b>School Work</b>       | <input type="checkbox"/> Simplify tasks (i.e. 3 step instructions)<br><input type="checkbox"/> Short breaks (5 minutes) between tasks<br><input type="checkbox"/> Reduce overall amount of in-class work<br><input type="checkbox"/> Prorate workload (only core or important tasks) /eliminate non-essential work<br><input type="checkbox"/> No homework<br><input type="checkbox"/> Reduce amount of nightly homework<br>_____ minutes per class; _____ minutes maximum per night<br><input type="checkbox"/> Will attempt homework, but will stop if symptoms occur<br><input type="checkbox"/> Extra tutoring/assistance requested<br><input type="checkbox"/> May begin make-up of essential work |                             |
| <b>Testing</b>           | <input type="checkbox"/> No Testing<br><input type="checkbox"/> Additional time for testing/ untimed testing<br><input type="checkbox"/> Alternative Testing methods: oral delivery of questions, oral response or scribe<br><input type="checkbox"/> No more than one test a day<br><input type="checkbox"/> No Standardized Testing   |                             |
| <b>Educational Plan</b>  | <input type="checkbox"/> Student is in need of an IEP and/or 504 Plan (for prolonged symptoms lasting >3 months, if interfering with academic performance)  |                             |
| <b>Physical Activity</b> | <input type="checkbox"/> No physical exertion/athletics/gym/recess<br><input type="checkbox"/> Walking in PE class/recess only<br><input type="checkbox"/> May begin return to play   |                             |