Muhlenberg School District
Health Services Department
Concussion Guidelines for Educators

Student Name: ________________________________  DOB: ______________________

Date of evaluation: ____________________________  Date of Injury: ________________

☐ No concussion present - student may participate in full academic activity, physical education and sports participation

☐ Concussion resolved - may return to all normal academic and physical activity without restrictions.

☐ Diagnosis of concussion:

Until this student is fully recovered, the following supports are recommended: (check all that apply)

☐ No return to school until (date) ___________________.

☐ Return to school with following supports:
  ☐ Shortened day: half days by alternating AM and PM attendance.
  ☐ Allow extra time to complete coursework/assignments and tests.
  ☐ Lessen homework load.
  ☐ No homework or major projects.
  ☐ No significant classroom testing/ quizzes or standardized testing at this time.
  ☐ Untimed tests and quizzes allowed.
  ☐ No band, orchestra, chorus or music classes to include extracurricular school activities, i.e. marching band, school musical practice/performance.
  ☐ Computer work and screen time as tolerated with scheduled breaks
  ☐ No computer/screen time allowed
  ☐ No physical education class/sports until further notice
  ☐ May do low levels of non-contact physical activity. This includes walking, light jogging, light stationary biking, and light weightlifting (lower weight, higher reps, no bench, no squat). Student should stop if symptoms worsen.
  ☐ Gradual return to sports practices under the supervision of an appropriate health care provider (e.g., athletic trainer or certified school nurse).

☐ May resume full academic activity, which is to be made up gradually over 10 school days.

Follow up Appointment date: ______________________

Health Care Provider Signature: ____________________________  Name of Practice Group: ____________________________

Health Care Provider (Please Print): ____________________________  License#: ____________________________

Phone #: ____________________________  Fax#: ____________________________

***THIS NOTE WILL BE IN EFFECT UNTIL STUDENT RECEIVES MEDICAL PROVIDER CLEARANCE and UPDATED FORM***