

SCARSDALE POST HEAD INJURY/CONCUSSION CARE PLAN - PHYSICIAN ORDERS FOR SCHOOL

Patient's Name: _____

Patient's DOB: _____

DIAGNOSIS: ☐ CONCUSSION ☐ NO CONCUSSION

Returning to PHYSICAL EDUCATION/SPORTS

NOTE: You should NEVER return to play if you still have ANY symptoms. Be sure that you do not have any symptoms at rest, during activities of daily living, or during activities that require a lot of thinking/concentration.

The following are recommended at the present time: *(M.D. check all that apply)*

- ☐ Do not return to P.E. class at this time
- ☐ Full, unrestricted return to P.E. class. *Date:* _____
- ☐ Do not return to sports practices/games at this time
- ☐ **Gradual** return to play under the supervision of an appropriate health care provider (e.g., athletic trainer, coach, or physical education teacher)
- ☐ Full, unrestricted return to sports. *Date:* _____

Additional Notes/Instructions: _____

Returning to SCHOOL

Until you (or your child) have fully recovered, **the following supports are recommended:** *(M.D. check one of the following)*

- ☐ Full return to school, no restrictions. *Date:* _____
- ☐ No return to school. Return on *(date)*: _____
- ☐ Return to school with following supports. *Review on date:* _____ *(M.D. check all that apply)*

NOTE: *Academic accommodations below are only applicable if student is NOT cleared to resume PE/Sports*

- ☐ Shortened school day. Recommended _____ hours per day until *(date)*: _____
- ☐ Shortened classes (i.e., rest breaks during classes). Suggested class length: _____ minutes
- ☐ Allow extra time to complete coursework/assignments and tests
- ☐ Reduced homework load. Max length of nightly homework: _____ minutes
- ☐ No significant classroom or standardized testing at this time
- ☐ Take rest breaks during the day as needed
- ☐ Check for the return of symptoms when doing activities that require a lot of attention or concentration
- ☐ Request meeting with School Management Team to discuss this plan and coordinate accommodations

Additional Notes/Recommendations: _____

Scarsdale Return to Play Protocol Summarized

Each step must be supervised by the appropriate health care provider

1. Light aerobic activity
2. Moderate activity/sport-specific activity
3. Non-contact training skills/practice
4. Full contact practice
5. Return to game play/competition

Athletes must receive final clearance from Dist MD prior to starting RTP

Follow-Up/Referral Plan *(M.D. check all that apply)*

- ☐ Follow-Up: Return to this office for re-evaluation, monitoring, adjustment of support plan.

Date/Time: _____

- ☐ None needed, recovery complete

Refer to: ☐ Neurology ☐ Neuropsychology

☐ Sports Medicine ☐ Psychiatrist

☐ Other: _____

Healthcare Provider Information:

Date: _____

Signature: _____

Address/Stamp: _____