West Chester Area School District

Concussion Accommodation Form for Treating Physicians

Student Name: ___________________________________ Date: __________

______Please excuse the patient named above from school today due to a medical appointment.

______This student is unable to participate in any academic endeavors at this time. Please have teachers identify and provide critical missed material for the student as they should be expected to review these materials when they are able to return to a full academic load. An effort will be made to do this earlier if the student is well enough to tolerate it. (Note: Students will only receive a medical for one marking period. If the accommodation needs to continue longer than one marking period, an alternate method to meet course requirements will be developed through an individual student plan.)

______Will return to school on __________ with the following restrictions until___________. (Accommodations will be in effect for no longer than one month without updated medical information indicating medical necessity.)

_________This student is able to participate in a reduced school day on (____hours/day) as tolerated. Preference for attendance: ______Alternating every other day schedule to include early and late classes.
_________Reduced workload to include only essential learning tasks
_________No tests or quizzes
_________No major projects
_________No homework.
_________Homework limited to ________hours/day.
_________Preprinted class notes as available.
_________Un-timed tests and quizzes.
_________No band/orchestra/chorus/music lessons
_________No physical education class. Please do not add alternative academic requirements.
_________Restricted physical education class activity: Light aerobic exercise only as tolerated.
_________No high stakes testing

______May return to full academic load without restrictions.

______May return to physical education without restrictions as tolerated.

______Please allow the student easy access to the school nurse. The parents should be notified of any nurse visits.

Medication to be given for headache____________________________.

______Other:____.

The student will be seen for Follow-Up in ________week(s). Updated accommodations provided at that time.

Printed Doctor's Name: ______________________________________

Doctor's Signature: ____ Date____________________

M-70 10/12; 12/14