

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 _____