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_____

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