Return to Learn Form

Today's Date: ________________

______________________________ was cared for in our office for ________________, The student may need the following marked academic adjustments at school until ______________(date).

School Attendance:

No return to school. May return on (date) ________________

Shortened day. Recommend ___ hours per day until (date) ________________

Other: ______________________________________________________________________

Breaks:

Allow student to go to health office if symptoms worsen

Other: ______________________________________________________________________

Workload:

Minimize overall amount of makeup work, class work, and homework when possible

No homework

Preprinted notes for class if possible

Other: ______________________________________________________________________

Testing:

No testing until cleared

No more than one test per day

Oral testing/open book/open note/take home testing

Allow extra time to complete tests/quizzes

Other: ______________________________________________________________________

Visual Stimulus:

Minimize smart boards, projectors, computers, TV screens or other bright screens

Enlarge font if possible

No computer classes

Other: ______________________________________________________________________

Audible Stimulus:

No music or band class

No Tech Ed, shop, or automotive class

Student should be allowed to eat lunch in quiet, supervised room

Other: ______________________________________________________________________

Additional Recommendations: ______________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

Physician Name/Signature: ___________________________________ Phone: __________________________

Follow up doctor appointment date: ________________

Parent Name/Signature: ____________________________________________
Gradual Return to Play Plan

Doctor, please indicate the following activity at this time:

___ No PE

___ No Sports

___ Return to PE Class with the following restrictions: (please check one)

___ Cleared for Low Levels of physical activity ONLY (This includes walking, light jogging, light stationary biking, light weightlifting (lower weight, higher reps, no bench, no squat).

___ Cleared for Moderate levels of physical activity with body/head movement ONLY
(This includes moderate jogging, brief running, moderate-intensity stationary biking, moderate-intensity weightlifting (reduced time and/or reduced weight from your typical routine).

___ Cleared for Heavy non-contact physical activity ONLY. (This includes sprinting/running, high-intensity stationary biking, regular weight-lifting routine, non-contact sport-specific drills (in 3 planes of movement).

___ NO RESTRICTIONS

___ Return to SPORTS with the following restrictions: (please check one)

___ Non-contact sport-specific drills (in 3 planes of movement) ONLY

___ Full contact practice ONLY

___ Full contact game play

Comments: ________________________________________________________________

Physician Name/Signature: ______________________________ Date: __________

Phone: ______________________________

Parent Name/ Signature: ______________________________ Date: __________

Developed: 1/2014 References: CDC "Heads Up: Brain Injury in Your Practice"; Children's Hospital of Wisconsin