Loudoun County Public Schools
Physician Order for Concussion

Date:______________    School:__________________________________________
Student’s Name:____________________________________   Grade:__________

The following symptoms are present today (circle or check).   _____No reported symptoms

<table>
<thead>
<tr>
<th>Physical</th>
<th>Thinking</th>
<th>Emotional</th>
<th>Sleep</th>
</tr>
</thead>
<tbody>
<tr>
<td>Headaches</td>
<td>Sensitivity to light</td>
<td>Feeling mentally foggy</td>
<td>Irritability</td>
</tr>
<tr>
<td>Nausea</td>
<td>Sensitivity to noise</td>
<td>Problems concentrating</td>
<td>Sadness</td>
</tr>
<tr>
<td>Fatigue</td>
<td>Numbness/Tingling</td>
<td>Problems remembering</td>
<td>Feeling more emotional</td>
</tr>
<tr>
<td>Visual problems</td>
<td>Vomiting</td>
<td>Feeling slow in responses</td>
<td>Nervousness</td>
</tr>
<tr>
<td>Balance Problems</td>
<td>Dizziness</td>
<td></td>
<td>Trouble falling asleep</td>
</tr>
</tbody>
</table>

**Exertional Effects:**
Do symptoms worsen with physical activity? Yes____  No____  No opportunity to assess____

**Returning to School**
Contact parent if the following symptoms are observed:
- Increased problems paying attention or concentrating
- Increased problems remembering or learning new information
- Longer time needed to complete tasks or assignments
- Greater irritability, less able to cope with stress
- Symptoms worsen (e.g., headache, tiredness) when doing schoolwork

**Returning to Learning**
Until fully recovered, the following accommodations are recommended: (check all that apply)

- Return to school on (date) __________________________________________________
- Shortened day. Recommend ____ hours per day until (date) ____________________________
- Shortened classes. Maximum class length: ____ minutes.
- Allow extra time to complete homework, tests and quizzes.
- Decrease homework load by ____%. Maximum length of nightly homework: ____ minutes.
- No significant classroom or standardized testing at this time.
- Check for the return of symptoms (use symptom table on front page of this form) when doing activities that require a lot of attention or concentration.
- Take rest breaks during the day as needed.
- Snack to be eaten as needed.
- No music or band classes.
- No eating in cafeteria.
- No computer work.
- Computer work allowed for ____ minutes per day.
- Avoid crowded hallway.

**Returning to Physical Activity**
All Students:
- Do not return to PE class/recess/ intramurals at this time.
- Return to PE class/recess/ intramurals.
- Limited return (specify activity).
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Middle School and High School:
___ Do not return to sports practices/games at this time.
___ Gradual return to sports practices under the supervision of athletic trainer. (See plan below)

**Gradual Return to Play Plan**

If symptoms occur during any of the following Steps, the athlete must cease activity and be re-evaluated and cleared once again by their healthcare provider.

**Step 1** No physical activity until asymptomatic. Athlete must remain asymptomatic in order to progress to the next Step. If symptoms return during any of the Steps, the student athlete must return to the previous Step.

**Step 2** Light exercise, including walking or riding an exercise bike. No weight lifting.

**Step 3** Running in the gym or on the field. No helmet or other equipment.

**Step 4** Non-contact training drills in full equipment. Weight training can begin.

If after Step 4, there are no symptoms of concussion, the athlete will be given a cognitive test before going on to **Step 5**. If the athlete does not clear on the second ImPACT evaluation, they will repeat the Steps above and have another ImPACT evaluation after **Step 4**.

**Step 5** Full Contact practice or training.

**Step 6** Game-play with release from Approved Healthcare Professional (MD- Medical Doctor, DO- Doctor of Osteopathic Medicine, PA- Physician Assistant, CNP- Certified Nurse Practioner, ATC- Certified Athletic Trainer, or Neuropsychologist).

Additional Instructions:

__________________________________________

**Follow Up Plan**

___ Return to this office. Next appointment ______________________.

___ Refer to: Neurosurgery ___ Neurology ___ Sports Medicine ___ Physiatrist ___ Psychiatrist ___ Other ___

___ Refer for neuropsychological testing.

___ Other _________________________________________________________________________________

Parent signature gives permission for principal’s designee to follow this plan, and to contact physician/healthcare provider, if necessary.

Parent/Guardian Signature ___________________________ Date __________

_________________________ __________________________
Physician/Healthcare Provider Signature Date

____________________ ______________________
Physician’s Printed Name/Address Phone Number Fax Number

_________________________ __________________________
School Nurse’s Signature Date Received