# 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

| Physical | | Thinking | Emotional | Sleep |
|---|---|---|---|---|
| Headaches | Sensitivity to light | Feeling mentally foggy | Irritability | Drowsiness |
| Nausea | Sensitivity to noise | Problems concentrating | Sadness | Sleeping more than usual |
| Fatigue | Numbness/Tingling | Problems remembering | Feeling more emotional | Sleeping less than usual |
| Visual problems | Vomiting | Feeling slow in responses | Nervousness | Trouble falling asleep |
| Balance Problems | Dizziness | | | |

**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**