Muscogee County School District
Student Health Services
CONCUSSION STUDENT HEALTH CARE PLAN

Please bring or mail this health care plan to the school.
A new health care plan is required every school year.

Student: _____Date of Birth: _____School year: _____

School: _____Teacher: _____Grade/Team: _____

Emergency Contacts

Parent/Guardian/Contact	Relationship	Phone Number	Alternate Phone Number
Primary Healthcare Provider:		**Phone Number:**	

Date Concussion occurred: _____ Date Child May Return to School: _____

□ Activity restrictions (*review physical exertion below*) □ Cleared for full activity

Please allow the following recommendations from date _____ through date _____

Attendance
- □ No school for _____ school day(s)
- □ No school until symptom free or significant decrease in symptoms
- □ Part time attendance for _____ days as tolerated
- □ Full school days as tolerated
- □ Other _____

Visual/ Light Sensitivity
- □ Allow to wear sunglasses in school
- □ Allow access to darkened area to rest for _____ minutes
- □ Contact parent to go home if symptoms do not subside
- □ Other _____

Auditory Sensitivity
- □ Allow to leave class 5 min early to avoid noisy hallways
- □ Lunch in a quiet place
- □ Allow access to quiet area to rest for _____ minutes
- □ Contact parent to go home if symptoms do not subside
- □ Other _____

2/2018
School Nurse Sharepoint Document Location: Forums > Care Plans

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Physical Exertion

- ☐ No physical exertion/athletics/gym/after school activities
- ☐ No recess
- ☐ Light aerobic activities only
- ☐ Non-contact/non-collision activities only
- ☐ Begin return to play protocol prior to returning to gym, athletics, after school activities
- ☐ Allow return to after school activities as observer only
- ☐ Allow return to after school activities as participant
- ☐ No restrictions for physical exertion/athletics/gym/after school activities

Breaks

- ☐ Allow access to nurse's office if symptoms persist
- ☐ Allow access to increased water intake
- ☐ Allow access to restroom if increased water intake
- ☐ Other _____

Additional Recommendations: _____

_____

_____

_____

Current Symptom List

- ☐ Headache
- ☐ Difficulty concentrating
- ☐ Sensitivity to light
- ☐ Trouble falling asleep
- ☐ Visual problems
- ☐ Difficulty remembering
- ☐ Sensitivity to noise
- ☐ Drowsiness
- ☐ Dizziness
- ☐ Feeling slowed down
- ☐ Feeling more emotional
- ☐ Sleeping less than usual
- ☐ Nausea
- ☐ Feeling mentally foggy
- ☐ Irritability
- ☐ Sleeping more than usual
- ☐ Fatigue
- ☐ Balance problems

Pain Management

√ Given at school	Medication Name	Dosage(amount)/Time	When to use

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Comments and Special Instructions (including school activities, sports, field trips, etc):

_____

_____

_____

_____

Physician's Authorization

My signature provides for the above orders. I understand that all procedures must be implemented within state laws and regulations. This authorization is valid for one year.

- ☐ If changes are indicated, I will provide new written authorized orders
- ☐ Dose/treatment changes may be relayed through parent/guardian.

Physician's Name: _____ Phone Number: _____

Physician's Signature: _____ Date: _____

Parent/Guardian Consent for Management of Concussion at School

I _____(Parent/Guardian) hereby authorize the named Healthcare Provider who has attended to my child, to furnish to the School Health Services Nurse and/or School Clinic Staff any medical information and/or copies of records pertaining to my child's concussion and for this information to be shared with pertinent school staff at my child's school. I understand that as of April 14, 2003, under the Health Insurance Portable and Accountability Act ("HIPAA") disclosure of certain medical information is limited. However, I expressly authorize disclosure of information so that my child's medical needs may be served while in attendance in the Muscogee County Schools. This authorization expires as of the last day of the school year.

I request designated school personnel to administer the medication and treatment orders as prescribed above. I agree to provide the necessary supplies and equipment and to notify the school nurse if there is a change in the student's health management or health care provider.

I understand that it is my responsibility to notify the bus driver, school administration, teacher, clinic worker and school nurse of any and all health conditions for my child.

Parent/Guardian's Signature: _____ Date: _____