Form 142-5

Documentation for a Diagnosed Concussion – Return to Learn/Return to Physical Activity Plan

This form is to be used by parents/guardians to communicate their child's/ward's progress through the plan and is to be used with "Concussion Management Procedures: Return to Learn and Return to Physical Activity".

The Return to Learn/Return to Physical Activity Plan is a combined approach. Step 2a - Return to Learn must be completed prior to the student returning to physical activity. Each step must take a minimum of 24 hours (Note: Step 2b – Return to Learn and Step 2 – Return to Physical Activity occur concurrently).

Step 1 – Return to Learn/Return to Physical Activity

- *Completed at home.*
- *Cognitive Rest – includes limiting activities that require concentration and attention (e.g., reading, texting, television, computer, video/electronic games).*
- *Physical Rest – includes restricting recreational/leisure and competitive physical activities.*

❑ My child/ward has completed Step 1 of the Return to Learn/Return to Physical Activity Plan (cognitive and physical rest at home) and his/her **symptoms have shown improvement**. My child/ward will proceed to Step 2a – Return to Learn.

❑ My child/ward has completed Step 1 of the Return to Learn/Return to Physical Activity Plan (cognitive and physical rest at home) and is **symptom free**. My child/ward will proceed directly to Step 2b – Return to Learn and Step 2 – Return to Physical Activity.

Parent/Guardian signature: _____ Date: _____

Comments: _____
_____
_____

Form 142C4

Documentation for a Diagnosed Concussion – Return to Learn/Return to Physical Activity Plan

Step 2a – Return to Learn

- *Student returns to school.*
- *Requires individualized classroom strategies and/or approaches which gradually increase cognitive activity.* ***Teacher may refer to Return to Learn: Accommodations and Strategies Sheet (pink).***
- *Physical rest– includes restricting recreational/leisure and competitive physical activities.*

❑ My child/ward has been receiving individualized classroom strategies and/or approaches and is **symptom free**. My child/ward will proceed to Step 2b – Return to Learn and Step 2
– Return to Physical Activity.

Parent/Guardian signature: _____ Date: _____

Comments: _____
_____
_____

Return of Symptoms

❑ My child/ward has experienced a return of concussion signs and/or symptoms and has been examined by a medical doctor/nurse practitioner, who has advised a return to:

- Step ____ of the Return to Learn/Return to Physical Activity Plan

Parent/Guardian signature: _____

Date: _____

Comments:

_____

_____

Step 2b and Step 2 Happen Simultaneously.

Step 2b – Return to Learn

- *Student returns to regular learning activities at school.*

Step 2 – Return to Physical Activity

- *Student can participate in individual light aerobic physical activity only.*
- *Student continues with regular learning activities.*

❑ My child/ward is symptom free after participating in light aerobic physical activity. My child/ward will proceed to Step 3 – Return to Physical Activity.

❑ This form **(Documentation for a Diagnosed Concussion – Return to Learn/Return to Physical Activity Plan)** will be returned to the teacher to record progress through Steps 3 and 4.

Parent/Guardian signature: _____ Date: _____

Comments: _____
_____
_____

Return of Symptoms

❑ My child/ward has experienced a return of concussion signs and/or symptoms and has been examined by a medical doctor/nurse practitioner, who has advised a return to:

- Step_____of the Return to Learn/Return to Physical Activity Plan

Parent/Guardian signature: _____

Date: _____

Comments:

_____

_____

Step 3 and 4 Involve the Teacher/Coach observation and Medical Doctor/Nurse Practitioner

Step 3 – Return to Physical Activity

- *Student may begin individual sport-specific physical activity only.*

Step 4 – Return to Physical Activity

- *Student may begin activities where there is no body contact (e.g., dance, badminton); light resistance/weight training; non-contact practice; and non-contact sport-specific drills.*

❑ Student has successfully completed Steps 3 and 4 and is symptom free. (Teacher or School Contact to check box)

Form is returned to parent/guardian for them to take to the medical doctor/nurse practitioner for examination and signature

Medical Examination

❑ I, _____ (medical doctor/nurse practitioner name) have examined _____ (student name) and confirm he/she continues to be symptom free and is able to return to regular physical education class/intramural activities/interschool activities in non-contact sports and full training/practices for contact sports.

Medical Doctor/Nurse Practitioner Signature: _____ Date: _____

Comments: _____
_____
_____

Step 5 – Return to Physical Activity

- Student may resume regular physical educational/intramural activities/interschool activities in non-contact sports and full training practices for contact sports

Return of Symptoms

❑ My child/ward has experienced a return of concussion signs and/or symptoms and has been examined by a medical doctor/nurse practitioner, who has advised a return to:

- Step_____of the Return to Learn/Return to Physical Activity Plan

Parent/Guardian signature: _____

Date: _____

Comments:

_____

_____

Parent/Guardian signature: _____ Date: _____

Comments: _____
_____

Step 6 – Return to Physical Activity

- Student may resume full participation in contact sports with no restrictions.

Return of Symptoms

❑ My child/ward has experienced a return of concussion signs and/or symptoms and has been examined by a medical doctor/nurse practitioner, who has advised a return to:

- Step_____of the Return to Learn/Return to Physical Activity Plan

Parent/Guardian signature: _____

Date: _____

Comments:

_____

_____