SPOKANE INTERNATIONAL ACADEMY

Parent/Guardian Care Plan Review by Phone:
Nurse:_____ Date:_____
Nurse:_____ Date:_____
Nurse:_____ Date:_____

SIA HEALTH SERVICES
777 E Magnesium Rd. Spokane, WA 99208 - (509) 209-8730 - Fax (509) 321-9650

Concussion Health Care Plan

Student's Name: _____ School Year: _____ Grade: _____

School Nurse: _____ Nurse Phone: _____

DEFINITION: A concussion is a mild brain injury usually resulting after a blow to the head. This event can cause a temporary impairment of brain function. A person with a concussion is at risk for a recurrence and needs to take precautions to avoid another injury.

SIGNS/SYMPTOMS

Physical		Cognitive & Emotional	
Headaches	Visual problems	Mentally foggy	Irritability
Nausea/vomiting	Balance Problems	Problems concentrating	Sadness
Fatigue/ sleepiness	Sensitivity to light or noise	Problems remembering	Nervousness
Sleeping Difficulty	Numbness/tingling	Feels like in slow motion	Feeling more emotional
Dizziness	Ringing in Ears		
Neck Pain			

ACTION PLAN

1. Health Care Provider will determine when student may return to school.
   a. Estimated date of return _____.
   b. Hours allowed to be at school_____.
   c. Shorten Day? Recommended_____ Until (date) _____.
2. Health Care Provider will determine activity restriction
   a. PE Recommendations: _____.
   b. Recess Recommendation: _____.
   c. Extra-Curricular Activity Recommendations: _____.
3. Staff may need to lessen work/homework load to allow for adequate cognitive rest.
   a. Allow extra time to complete tasks.
   b. No significant classroom or standardized testing at this time might be requested. It might not be an accurate assessment of the student's abilities.
4. Staff will give the student rest breaks during the day as needed.
5. Staff will understand the student may be irritable and less able to cope with stress.
6. Call parent for all head bumps regardless how mild.
7. If mild symptoms: allow student rest in the health room and/or receive medication ordered by the doctor.
8. If moderate symptoms: Call parent. Student may need to go home or to obtain a medical evaluation.
9. Staff will continue to monitor student for: **SERIOUS SYMPTOMS – call 911**

Severe Headache or Neck Pain	Seizure or Loss of Consciousness	Very Drowsy, Unable to Awaken
Repeated Vomiting	Increased Confusion	Weakness/Numbness in Arms/Legs
Slurred Speech	Unequal Pupil size or Double Vision	Unusual Behavior Change

10. If student has a seizure – Don't restrain movements, protect from injury and position on side to prevent aspiration. If student stops breathing – start CPR/Call 911.

INDIVIDUAL STUDENT CONSIDERATIONS:

Student Name _____

Contact Information

Parent/Guardian Name _____ Parent/Guardian Phone Number _____
Parent/Guardian Name _____ Parent/Guardian Phone Number _____
Doctor's Name _____ Clinic's Name _____ Contact Phone Number _____

Returning to Daily Activities

1. Get plenty of rest. Be sure to get enough sleep at night, therefore, no late nights staying awake. Keep the same bedtime weekdays and weekends.
2. Take daytime naps or rest breaks when you feel tired or fatigued.
3. Drink plenty of fluid and eat carbohydrates and/or protein to maintain appropriate blood sugar levels.
4. The following activities can make symptoms worse:
   -Physical activity: PE class, sports, weight-training, exercising, heavy lifting, etc.
   -Thinking and concentration activities: homework, classwork, job-related activities, electronic devices, television, driving, etc.
5. As symptoms decrease, you may begin to gradually return to your daily activities as directed by your physician. While returning to activities it is recommended to repeat evaluation of your symptoms to help guide your recovery. If symptoms worsen or return, reduce your activity load, and then try again to increase your activities gradually.
6. During recovery, it is normal to feel frustrated and sad when you are experiencing symptoms and cannot be as active as usual.

Returning to School / Work

1. If you are still having symptoms of concussion, you may need extra help to perform school or work related activities. As your symptoms decrease during recovery, the extra help or supports can be removed gradually.
2. Inform personnel around you (teachers, nurse, co-workers, psychologist/counselor, supervisors, and administrators about your injury and symptoms. Personnel should be instructed to watch for:
   -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 (headache, tiredness, etc) when doing work or school related tasks

CLASSROOM/SCHOOL The following are recommended at the present time (check all that apply):

- ☐ Cleared to return to school and activities of daily living without restrictions.
- ☐ Not cleared to return to school until further notice.
- ☐ Return to school/work with following supports on (date) _____.

Additional instructions:_____.

Returning to Physical Activity/Sports

1. You should **NEVER** return to play if you have **ANY** symptoms, therefore you should have **NO** symptoms at rest, doing any physical activity, or activities that require thinking/concentration.

2. Be sure that the school nurse and/or physician are aware of your injury and symptoms. It is very important to be completely honest about how you are feeling and whether or not you are experiencing any symptoms.

3. It is normal to feel frustrated, sad, and even angry because you cannot return to sports right away. With any injury, a full recovery will reduce the chances of becoming injured again.
   It is better to miss one or two games rather than the whole season.

---

*The athlete named below has suffered a concussion, and may not return to **ANY** contact sport activity (practice, games, contact drills, etc.) until cleared by this clinic. Please see below for permitted levels of exertion:*

PATIENT NAME:_____

☐ Cleared to FULLY return to physical activity/sport participation without restriction.

☐ Not cleared for physical activity at this time (includes PE, sport practices/games, weight training, etc). NO physical exertion until next clinic visit. **(Date of next clinic visit**_____**)**

☐ Gradual return to physical activity under the supervision of a physician.
*If student is in a secondary school, student may be required to obtain clearance by the school's athletic trainer before participating in school sports. This may entail Impact testing.
* If the physician doesn't give parameters of gradual return to physical activities, the REAP guidelines will be followed.

Call our office for further recommendations.

Additional Instructions: _____
_____
_____.

This referral plan is based on today's evaluation:

Return to this office: Date / Time_____

Refer to: Neurology_____ Optometry_____Neurospsychology_____ Vestibular Therapy_____

Nutritionist_____ Physical Therapy_____ Psychiatrist_____Hyperbarics_____

Other:_____

Plan completed by: _____
(Licensed Health Care Provider)

Parent's Signature _____ Date _____

Nurse Signature _____ Date _____