Mount Prospect School District 57
Concussion Health Care Plan

Student Name: ____

Grade: ____

Date/Time of Injury: ____

The above patient has been diagnosed with a concussion and is currently under our care.

Excusal:

In conjunction with the Center for Disease Control and Prevention (CDC) guidelines for concussions in school, please allow my patient time to recover. Since concussion symptoms and recovery can be variable, the following accommodations may be necessary to achieve healing:

- ☐ Full or partial day absences from school
- ☐ Limited homework and testing
- ☐ No physical activity, or restricted activity as tolerated
- ☐ Decreased visual and sound stimuli
- ☐ Breaks in school day as needed
- ☐ Other____________________________

Period of time:

If symptoms worsen or do not resolve, the patient should be reevaluated in my office. I have instructed the patient and parents on concussion care and warning signs.

I have added my personal recommendations as follows:

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Date of follow up: ____

Healthcare Provider Signature: ______________________ Date: ____________

Parent Signature: ______________________ Date: ____________