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APPENDIX E

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 ***"Board Policy D-26 Concussion Protocol: Prevention, Identification and Management Procedures"***

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 a physical activity. Each step must take a minimum of 24 hours (Note: Step 2b – Return to Learn and Step 2 – Return to Physical Activity occurs 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: _____

_____

_____

If at any time during the following steps symptoms return, please refer to the "Return of Symptoms" section on page 4 of this form.

Step 2a – Return to Learn

- *Student returns to school.*
- *Requires individualized classroom strategies and/or approaches which gradually increase cognitive activity.*
- *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: _____

_____

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.

❑ Appendix C-4 will be returned to the teacher to record progress through Steps 3 and 4.

Parent/Guardian signature: _____

Date: _____

Comments: _____

_____

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.

❑ Appendix C-4 will be returned to parent/guardian to obtain medical doctor/nurse practitioner diagnosis and signature.

Teacher 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 education/intramural activities/interschool activities in non-contact sports and full training/practices for contact sports.*

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: _____

  _____

  _____

  _____