Return to School: Concussion

To be completed by Health Care Provider

Student: _____ Date: _____

***Student may not return to school until this form and all necessary documents are received by the Assistant Principals, Ms.* Pickren and Mr. Elorduy.**

TO WHOM IT MAY CONCERN:

_____ was seen in our office for an injury to the head. It was determined the
Student
student has a concussion.

☐ Our medical staff have determined this student can return to a full day of school on _____.
Date

OR

☐ The following accommodation(s) should be made for this student until he/she is re-evaluated. Student will be re-evaluated on _____, to determine whether a full return to school is possible.
Date

Select all that apply

- ○ Partial return to school (attend no more than 3 hours of school a day)
- ○ No tests or quizzes
- ○ No homework
- ○ No screentime
- ○ Other _____

_____

Sincerely,

_____ _____

Signature (Medical Doctor) ***Print Name***

Address: _____

Phone: _____ Fax: _____

On doctor's office letterhead, please attach discharge summary including diagnosis, treatment plan and/or any medication the student has been prescribed.

This information must be faxed or emailed to either Amanda Pickren or Julian Elorduy prior to student returning to school.

apickren@cbhs-sacramento.org jelorduy@cbhs-sacramento.org Fax: 916-733-3688