Return to Learn Accommodations

Dear Health Provider, Date: _____

_____ sustained a head injury and needs further evaluation for a potential concussion. Please use the zones on the form to indicate the student's level of injury and level of activity upon return to school, as this will help ensure compliance with TUSD Return to Learn Protocol.
Health provider follow up is required at least every four weeks to continue accommodations.

TUSD Staff Name: _____ School: _____Phone:_____

Concussion Guidelines

RED ZONE

☐ **Student needs total cognitive rest. Should not be in school or doing academic work.**

ORANGE ZONE

ALL ☐ **(or check each specific indication)**

- ☐ **Attendance may be inconsistent based on level of symptoms and time of day.**
- ☐ **Prioritize and excuse assignments based on most essential goals and objective of the course. Communicate this to parents, student, and other involved support staff.**
- ☐ **If student is symptomatic, send him or her to the nurse.**
- ☐ **Expect limited class participation (more listening than speaking)**
- ☐ **Avoid tests, quizzes, and computer or screen-based assignments**
- ☐ **May need audio books or oral exams**
- ☐ **Be prepared to help student accommodate light and noise sensitivity**
- ☐ **REMEMBER: Student may not be able to self-advocate**

YELLOW ZONE

ALL ☐ **(or check each specific indication)**

- ☐ **Excuse past assignments and units as possible.**
- ☐ **Student should only take one test or quiz a day**
- ☐ **Anticipate occasional absences**
- ☐ **Set a schedule for the completion of any work that cannot be excused**
- ☐ **Student may still require accommodations such as audio books, extended time on test or large assignments, and limited screen-based assignments**

GREEN ZONE

ALL ☐ **(or check each specific indication)**

- ☐ **For new work, academic expectations can be back to usual**
- ☐ **Student will be working to complete accommodated work load (according to agreed upon modifications) for all classes.**
- ☐ **REMEMBER: most students can not make up every assignment they missed**

BLUE ZONE

☐ **Back to usual academic expectations**

Date of follow-up appointment: _____

Name and Phone number of Provider: _____

Signature of Provider _____Date_____