Cabarrus County Schools
The Clear Choice

Concussion Temporary Academic Modification Form

Student Name: _____ DOB: _____

Homeroom Teacher: _____ Grade: _____

The above student has been deemed to have signs/symptoms consistent with a concussion. To initiate appropriate cognitive and physical rest, and allow the quickest recovery, the following modifications should be initiated. Parents must be notified.

To Promote Cognitive Recovery:

Allow extra time to complete homework/assignments.

No standardized testing.

Lessen screen time to 90 minutes maximum per day, and no more than 20 minutes continuous.

Lessen homework load by 50% per class.

To Address Symptoms:

Provide alternative setting during band/music class.

Provide alternative setting during PE class to avoid noise exposure and to decrease re-injury risk.

Allow student to use earplugs when in noisy environment, and to wear sunglasses or a hat with a bill worn forward to reduce light exposure.

If student has increasing or worsening symptoms during class (i.e. headache, nausea, dizziness or difficulty concentrating) they should report to the nurse's office for further evaluation.

School Nurse/Athletic Trainer Signature: _____ Date: _____

****These restrictions will expire 5 school days after the above date, unless otherwise changed by a medical provider.****

Signatures of teachers notified of these accommodations by SN: Date: _____

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