Olean High School Medical Office

410 W. Sullivan Street
Olean, NY 14760
Phone (716) 375-8005
Fax (716) 375-8277

Student Name:_____ Date of Birth:_____ Grade:_____

Date of Concussion: _____ Date of return to school:_____

The above named student requires the following short term academic supports for proper concussion management in school (checked items apply): **ALL ITEMS CHECKED APPLY UNTIL REVIEW DATE BELOW***

_____ No educational modification (always applies when cleared for PE & Sports/Athletics)

_____ Shortened day/Modified schedule: _____

_____ Extra time to complete class work, assignments, and tests

_____ No significant classroom testing or standardized testing

_____ Rest breaks during school day as needed for headache or fatigue

_____ Allow dismissal home if headache not resolved after rest in quiet area (Medical Office)

_____ Other: _____

_____

The above named student requires the following short term recommendations regarding physical education and/or Sports (checked items apply):

_____ Student is cleared to participate in gym class & athletics without restrictions

_____ Student may NOT participate in gym class or athletics/sports until further notice

_____ Student may return to gym class/sports utilizing the "RAMP UP" or gradual step process per school policy Under supervision of PE teacher, Coach, and/or Athletic Trainer.

The above recommendations will be reviewed and updated on next appointment on _____

Health Care Provider Signature:_____ Date: _____

Printed Name: _____ Telephone: _____