



**VERMILION CATHOLIC**  
*a legacy of Mount Carmel*

## **ATHLETIC PHYSICALS**

\*\*\*Must have a parent signature on physical\*\*\*

**WHEN:** May 4th, 2026

- High School Athletes @ 2:30
- Middle School Athletes @ 3:15

**WHERE:** Upper School Gym

**WHO:** All athletes who intend to play sports for the 2026-2027 school year

**COST:** \$10 donation. Local medical providers have graciously volunteered their time. The donation will go towards athletic training supplies needed for a successful year.

\*\* If you have any unused medical supplies that you are looking to get rid of, please feel free to bring them in for a donation (crutches, ace wraps, old braces, etc.) \*\*

Checklist of forms that you are required to turn in by the 1st practice/workout:

- \_\_\_ Physical Form
- \_\_\_ LHSAA Parental Permission Form
- \_\_\_ LHSAA Substance Abuse/Misuse Contract and Consent Form
- \_\_\_ LHSAA Student-Athlete and Parent Concussion Statement Form

## LHSAA MEDICAL HISTORY EVALUATION

IMPORTANT: This form must be completed *annually*, kept on file with the school, and is subject to inspection by the Rules Compliance Team.

Please Print

Name: \_\_\_\_\_ School: \_\_\_\_\_ Grade: \_\_\_\_\_ Date: \_\_\_\_\_  
 Sport(s): \_\_\_\_\_ Sex: M / F Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Home Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
 Parent / Guardian: \_\_\_\_\_ Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_

**FAMILY MEDICAL HISTORY:** Has any member of your family under age 50 had these conditions?

<b>Yes No Condition Whom</b>	<b>Yes No Condition Whom</b>	<b>Yes No Condition Whom</b>
<input type="checkbox"/> <input type="checkbox"/> Heart Attack/Disease _____	<input type="checkbox"/> <input type="checkbox"/> Sudden Death _____	<input type="checkbox"/> <input type="checkbox"/> Arthritis _____
<input type="checkbox"/> <input type="checkbox"/> Stroke _____	<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure _____	<input type="checkbox"/> <input type="checkbox"/> Kidney Disease _____
<input type="checkbox"/> <input type="checkbox"/> Diabetes _____	<input type="checkbox"/> <input type="checkbox"/> Sickle Cell Trait/Anemia _____	<input type="checkbox"/> <input type="checkbox"/> Epilepsy _____

**ATHLETE ORTHOPAEDIC HISTORY:** Has the athlete had any of the following injuries?

<b>Yes No Condition Date</b>	<b>Yes No Condition Date</b>	<b>Yes No Condition Date</b>
<input type="checkbox"/> <input type="checkbox"/> Head Injury / Concussion _____	<input type="checkbox"/> <input type="checkbox"/> Neck Injury / Stinger _____	<input type="checkbox"/> <input type="checkbox"/> Shoulder L / R _____
<input type="checkbox"/> <input type="checkbox"/> Elbow L / R _____	<input type="checkbox"/> <input type="checkbox"/> Arm / Wrist / Hand L / R _____	<input type="checkbox"/> <input type="checkbox"/> Back _____
<input type="checkbox"/> <input type="checkbox"/> Hip L / R _____	<input type="checkbox"/> <input type="checkbox"/> Thigh L / R _____	<input type="checkbox"/> <input type="checkbox"/> Knee L / R _____
<input type="checkbox"/> <input type="checkbox"/> Lower Leg L / R _____	<input type="checkbox"/> <input type="checkbox"/> Chronic Shin Splints _____	<input type="checkbox"/> <input type="checkbox"/> Ankle L / R _____
<input type="checkbox"/> <input type="checkbox"/> Foot L / R _____	<input type="checkbox"/> <input type="checkbox"/> Severe Muscle Strain _____	<input type="checkbox"/> <input type="checkbox"/> Pinched Nerve _____
<input type="checkbox"/> <input type="checkbox"/> Chest _____	Previous Surgeries: _____	

**ATHLETE MEDICAL HISTORY:** Has the athlete had any of these conditions?

<b>Yes No Condition</b>	<b>Yes No Condition</b>	<b>Yes No Condition</b>
<input type="checkbox"/> <input type="checkbox"/> Heart Murmur / Chest Pain / Tightness	<input type="checkbox"/> <input type="checkbox"/> Asthma / Prescribed Inhaler	<input type="checkbox"/> <input type="checkbox"/> Menstrual Irregularities: Last Cycle: _____
<input type="checkbox"/> <input type="checkbox"/> Seizures	<input type="checkbox"/> <input type="checkbox"/> Shortness of breath / Coughing	<input type="checkbox"/> <input type="checkbox"/> Rapid weight loss / gain
<input type="checkbox"/> <input type="checkbox"/> Kidney Disease	<input type="checkbox"/> <input type="checkbox"/> Hernia	<input type="checkbox"/> <input type="checkbox"/> Take supplements/vitamins
<input type="checkbox"/> <input type="checkbox"/> Irregular Heartbeat	<input type="checkbox"/> <input type="checkbox"/> Knocked out / Concussion	<input type="checkbox"/> <input type="checkbox"/> Heat related problems
<input type="checkbox"/> <input type="checkbox"/> Single Testicle	<input type="checkbox"/> <input type="checkbox"/> Heart Disease	<input type="checkbox"/> <input type="checkbox"/> Recent Mononucleos
<input type="checkbox"/> <input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Enlarged Spleen
<input type="checkbox"/> <input type="checkbox"/> Dizzy / Fainting	<input type="checkbox"/> <input type="checkbox"/> Liver Disease	<input type="checkbox"/> <input type="checkbox"/> Sickle Cell Trait/Anemia
<input type="checkbox"/> <input type="checkbox"/> Organ Loss (kidney, spleen, etc)	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis	<input type="checkbox"/> <input type="checkbox"/> Overnight in hospital
<input type="checkbox"/> <input type="checkbox"/> Surgery	<input type="checkbox"/> <input type="checkbox"/> Prescribed EPI PEN	<input type="checkbox"/> <input type="checkbox"/> Allergies (Food, Drugs) _____
<input type="checkbox"/> <input type="checkbox"/> Medications _____		

List Dates for: Last Tetanus Shot: \_\_\_\_\_ Measles Immunization: \_\_\_\_\_ Meningitis Vaccine: \_\_\_\_\_

### PARENTS' WAIVER FORM

To the best of our knowledge, we have given true & accurate information & hereby grant permission for the physical screening evaluation. We understand the evaluation involves a limited examination and the screening is not intended to nor will it prevent injury or sudden death. We further understand that if the examination is provided without expectation of payment, there shall be no cause of action pursuant to Louisiana R.S. 9:2798 against the team volunteer health-care provider and/or employer under Louisiana law.

This waiver, executed on the date below by the undersigned medical doctor, osteopathic doctor, nurse practitioner or physician's assistant and parent of the student athlete named above, is done so in compliance with Louisiana law with the full understanding that there shall be no cause of action for any loss or damage caused by any act or omission related to the health care services if rendered voluntarily and without expectation of payment herein unless such loss or damage was caused by gross negligence. Additionally,

1. If, in the judgment of a school representative, the named student-athlete needs care or treatment as a result of an injury or sickness, I do hereby request, consent and authorize for such care as may be deemed necessary.....Yes No
2. I understand that if the medical status of my child changes in any significant manner after his/her physical examination, I will notify his/her principal of the change immediately.....Yes No
3. I give my permission for the athletic trainer to release information concerning my child's injuries to the head coach/athletic director/principal of his/her school.....Yes No
4. By my signature below, I am agreeing to allow my child's medical history/exam form and all eligibility forms to be reviewed by the LHSAA or its representative(s) or the associated medical personnel.....Yes No

Date Signed by Parent \_\_\_\_\_ Signature of Parent \_\_\_\_\_ Typed or Printed Name of Parent \_\_\_\_\_

#### II. COMPLETED ANNUALLY BY MEDICAL DOCTOR (MD), OSTEOPTAHIC DR. (DO), NURSE PRACTITIONER (APRN) or PHYSICIAN'S ASSISTANT (PA)

Height _____	Weight _____	Blood Pressure _____	Pulse _____
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<b>GENERAL MEDICAL EXAM :</b>	<b>ORTHOPAEDIC EXAM :</b>																																																																								
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Health Care Provider notes (if needed): \_\_\_\_\_

- Medically eligible for all sports without restriction  
 Medically eligible for certain sports  
 Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of \_\_\_\_\_  
 Not medically eligible pending further evaluation  
 Not medically eligible for any sports  
 This recommendation is from a limited screening.

Printed Name of MD, DO, APRN or PA \_\_\_\_\_ Signature of MD, DO, APRN or PA \_\_\_\_\_ Date of Medical Examination \_\_\_\_\_

# Louisiana High School Athletic Association

## Athletic Participation/Parental Permission Form

*This form must be completed and signed **by the student-athlete's parent** prior to a student's participation in an athletic contest and shall be kept on file with the school. **It shall remain in effect for the remainder of the student's eligibility unless the student transfers to another member school.** This form is subject to **review/inspection** by the LHSAA **or its representative.***

### **PART I: STUDENT INFORMATION** (Please Print)

Student's Name: (Last, First, Middle) \_\_\_\_\_ School Year: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Last Four Digits of SSN: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_

My child entered ninth grade in \_\_\_\_\_ (month and year). Last semester/year he/she attended \_\_\_\_\_ High School.

### **ARE YOU ELIGIBLE?**

A student athlete in an LHSAA school must meet the following rules to be eligible for interscholastic athletic competition:

<b><u>RULE</u></b>	<b><u>COMMENTS</u></b>
<b>BONA FIDE STUDENT</b>	A student shall be enrolled in and attending an LHSAA member school on a regular basis and taking the required number of subjects which shall be recorded on the student's official transcript unless student is a special education student or in the 8 <sup>th</sup> grade or below. A student shall must be counted as a student on the daily attendance records of the school he/she attends. Attendance in one class makes you a student at that school.
<b>ENROLLMENT</b>	A student shall be enrolled and attending a school in the first 11 school days of the school semester at any school or will be ineligible for the first 30 school days.
<b>AGE</b>	A student shall not become 19 years of age prior to August 1 of this year.
<b>PROOF OF AGE</b>	A student shall provide legal proof of age, which meets the provisions of the LHSAA handbook, to the school administrator to be kept on file at school.
<b>CONSECUTIVE SEMESTERS</b>	Once a student shall enter the ninth grade, he/she shall have eight consecutive semesters to play athletics.
<b>SCHOLASTIC</b>	For regular education high school students at the end of the first semester a student shall <b>pass at least six subjects</b> in all subjects taken.  At the end of the year and prior to the next school year, a student shall must have <b>earned at least six units with an overall "C" average for the entire previous school year</b> as determined by the LEA in all units taken. All seniors must take at least four (4) subjects each semester.  Special education students must consult the school principal, athletic director, or coach for scholastic information.
<b>RESIDENCE AND SCHOOL TRANSFERS</b>	Upon entering high school for the first time, a student shall have the choice to attend any member school located in the attendance zone in which the student resides with his/her parent(s)/guardian(s) or any other household with whom the student has been residing for the past calendar year and be immediately eligible unless an applicable exception applies. A transfer to another member school in the same attendance zone shall render the student ineligible for one calendar year.
<b>UNDUE INFLUENCE</b>	If a student shall has been recruited to a school for athletic purposes, he/she shall remain ineligible as long as the student attends that school.
<b>AMATEUR</b>	A student cannot play high school athletics if he/she loses their amateur status.
<b>INDEPENDENT TEAM</b>	In certain sports a student cannot play on a school team and an independent team during the same sport season.

**PLEASE RETURN**

**MEDICAL EXAMINATION**

A student shall **annually** pass a physical examination given by a licensed physician/ nurse practitioner that is in collaboration with a licensed physician or a licensed physician's assistant under the supervision of a licensed physician and complete an LHSAA Medical History Evaluation form prior to participating.

**ATHLETIC PARTICIPATION/**

**PARENTAL PERMISSION FORM**

A school shall **only** be required to have this form completed and signed prior to **the first time a student participates** in LHSAA athletics at the school **unless the student transfers to another member school.**

**SUBSTANCE ABUSE/MISUSE CONTRACT & CONSENT FORM**

A school shall only be required to have this form completed and signed prior to the first time a student participates in LHSAA athletics at the school.

**SUSPENDED AND INELIGIBLE STUDENTS**

Shall not participate in any interscholastic contest on any team at any school at any level.

**LHSAA ELIGIBILITY RULES APPLY TO STUDENT-ATHLETES ON ALL TEAMS AT ALL LEVELS OF PLAY AT ALL LHSAA SCHOOLS**

Eligibility to participate in interscholastic athletics is a privilege a student earns by meeting standards outlined on this form and other regulations and policies set by the LHSAA and the student's school. If you have questions or do not fully understand an eligibility rule, check with your child's principal, athletic director or coach. By following the intent and spirit of the rules, you can help prevent violations which may penalize the student, his/her team and/or his/her school.

**ONE INELIGIBLE STUDENT MAY DISQUALIFY YOUR WHOLE TEAM – KNOW THE ELIGIBILITY RULES**

**PART II – PARENTAL PERMISSION**

I have read and reviewed the general requirements for high school athletic eligibility on this form and have discussed these requirements with my child. I understand additional questions/explanations and specific circumstances should be directed to my child's principal, athletic director or coach.

I certify the home address listed **on this form** is my sole bona fide residence and **that I** will notify the school principal immediately of any change in **my** residence, since such a move may alter the eligibility status of my child. All other information given is also accurate and current.

I give my permission for the athletic trainer to release information concerning my child's injuries to the head coach/ athletic director/principal of his/her school. Additionally, I give the LHSAA or its representative(s) permission to review my child's scholastic records and all required eligibility forms **however submitted by the school or myself.**

If the medical status of my child changes in any significant manner after he/she passes his/her physical examination, I will notify his/her principal of the change immediately.

I hereby give my consent and approval for **my child** to participate in **any** of the following LHSAA sports:

- |               |              |                 |
|---------------|--------------|-----------------|
| BASEBALL      | GOLF         | SWIMMING        |
| BASKETBALL    | GYMNASTICS   | TENNIS          |
| BOWLING       | POWERLIFTING | TRACK AND FIELD |
| CROSS COUNTRY | SOCCER       | VOLLEYBALL      |
| FOOTBALL      | SOFTBALL     | WRESTLING       |

I certify all the information is correct, that I have read the summary of LHSAA eligibility rules below and I am in compliance with these standards. I also acknowledge that my child, by my signature below, has my permission to participate in interscholastic athletics during his attendance at this school. I also understand that this form shall only be completed prior to my child's first participation in any athletic contest of any sport and shall remain in effect for his/her entire athletic eligibility unless he/she transfers to another member school.

**By signing below, I agree that my child and I will support and comply with all rules, policies and procedures of the LHSAA as set forth in its Handbook, including its Constitution and Bylaws.**

Date: \_\_\_\_\_ Parent's Signature: \_\_\_\_\_

Relationship to Student \_\_\_\_\_ (Print Name) \_\_\_\_\_

(Principal Signature) Alexander Albut

**PLEASE RETURN**



## LHSAA SUBSTANCE ABUSE/MISUSE CONTRACT AND CONSENT FORM

*This form must be completed and signed and kept on file with the school and is subject to inspection by the LHSAA Rules Compliance Team.*

As an LHSAA athlete, I, \_\_\_\_\_, agree to avoid the abuse or misuse of legal or illegal substances, including anabolic steroids and other performance enhancing drugs. I hereby grant permission to be tested for substance abuse/misuse as a participant in any LHSAA sports program. I furthermore agree to cooperate by providing a urine or hair specimen for testing upon the request of my principal. I understand that should my specimen indicate the abuse or misuse of legal or illegal substances, I will be subject to action specified in my School Drug Policy for Student Athletes.

I, \_\_\_\_\_, parent/guardian of the undersigned student athlete, individually, and on behalf of my child, do hereby grant permission for and consent to said child being tested for substance abuse/misuse in accordance with his/her School Drug Policy for Student Athletes and I understand that if any specimen taken from him/her indicates abuse or misuse of legal or illegal substances, including anabolic steroids and other performance enhancing drugs, he/she will be subject to action specified in the School Drug Policy for Student Athletes for his/her school.

Dated: \_\_\_\_\_

\_\_\_\_\_  
Student Athlete

Dated: \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian

Dated: \_\_\_\_\_

*Alexander Albo*  
\_\_\_\_\_  
Principal

Dated: \_\_\_\_\_

*Ernest E. Jones*  
\_\_\_\_\_  
Head Coach or AD

**1.10 ABUSE AND/OR MISUSE OF ILLEGAL SUBSTANCES** - Each member school shall develop and implement a substance abuse/misuse policy including procedures for chemical testing of student-athletes. To be eligible for interscholastic athletics, prior to practicing or participating in a sport at an LHSAA school, a student-athlete and his/her parent(s)/guardian shall sign the LHSAA Substance Abuse/Misuse Contract developed and distributed to all schools by the LHSAA. Once signed, the LHSAA Substance Abuse/Misuse Contract shall remain in effect for the remainder of the student-athlete's eligibility. Schools may also have the student and parent/guardian sign a school issued form in addition to the LHSAA Substance Abuse/Misuse Contract. Schools shall be required to keep the signed form on file at the school.

**1.10.1** The penalties for failure to have the required LHSAA Substance Abuse/Misuse Contract(s) for all students completed, properly signed, and maintained in the school files shall be:

1. A school shall be fined \$50 per student, per sport for each LHSAA Substance Abuse/Misuse Form not completed, properly signed, and on file with the school not to exceed \$500 per sport.
2. A student in violation of this rule shall not be ruled ineligible for this infraction, but shall be withheld from further team practices and interscholastic athletic participation until a copy of this form is completed and submitted to the Executive Director. The completed form must be faxed or postmarked prior to the athlete's participation

**Signature of the LHSAA's contract does not necessarily mean the student athlete will be tested.**

**PLEASE RETURN**

**Louisiana High School Athletic Association**  
**Student-Athlete and Parent Concussion Statement**

After reading the CDC Heads Up Concussion Fact Sheets and reviewing the LHSAA Concussion Management Protocol, I am aware of the following information:

Athlete Initial:	Parent Initial:	
		A concussion is a brain injury which I am responsible for reporting to my coach, athletic trainer, or health care provider.
		A concussion can affect my ability to perform everyday activities, and affect reaction time, balance, sleep, and classroom performance. You cannot always see a concussion, but you might notice some of the symptoms right away. Other symptoms can show up hours or days after the injury.
		Athletes shall not return to play in a game or practice on the same day that they are suspected of having a concussion.
		Athletes diagnosed with a concussion must be assessed by a health care provider. Athletes will begin a graduated return to play protocol following full recovery of neurocognition and balance.
		Concussed athletes are much more likely to experience complications if they return to play before symptoms resolve including but not limited to permanent brain damage or even death.

I commit to the following:

Athlete Initial:	Parent Initial:	
		I will report all injuries and illnesses to my coach, athletic trainer and/or health care provider.
		I will not return to play in a game or practice if I have received a blow to the head or body that results in concussion-related symptoms.
		If I suspect a teammate has a concussion, I will report the injury to my coach, athletic trainer, or team health care provider.

\_\_\_\_\_  
Signature of Student-Athlete

\_\_\_\_\_  
Signature of Parent/Legal Guardian

\_\_\_\_\_  
Printed Name of Student-Athlete

\_\_\_\_\_  
Printed Name of Parent/Legal Guardian

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

This form must be kept on record with the school.

## A FACT SHEET FOR Parents



### What is a concussion?

A concussion is a type of brain injury that changes the way the brain normally works. A concussion is caused by a bump, blow, or jolt to the head. Concussions can also occur from a blow to the body that causes the head and brain to move rapidly back and forth. Even what seems to be a mild bump to the head can be serious. Concussions can have a more serious effect on a young, developing brain and need to be addressed correctly.

### What are the signs and symptoms of a concussion?

You can't see a concussion. Signs and symptoms of concussion can show up right after an injury or may not appear or be noticed until hours or days after the injury. It is important to watch for changes in how your child or teen is acting or feeling, if symptoms are getting worse, or if s/he just "doesn't feel right." Most concussions occur without loss of consciousness.

If your child or teen reports one or more of the symptoms of concussion listed below, or if you notice the signs or symptoms yourself, seek medical attention right away. Children and teens are among those at greatest risk for concussion.

## Signs & Symptoms of a Concussion

### Signs Observed by Parents or Guardians

- Appears dazed or stunned
- Is confused about events
- Answers questions slowly
- Repeats questions
- Can't recall events *prior* to hit, bump, or fall
- Can't recall events *after* hit, bump, or fall
- Loses consciousness (even briefly)
- Shows behavior or personality changes
- Forgets class schedule or assignments

### Symptoms Reported by Your Child or Teen

#### Thinking/Remembering

- Difficulty thinking clearly
- Difficulty concentrating or remembering
- Feeling more slowed down
- Feeling sluggish, hazy, foggy, or groggy

#### Physical

- Headache or "pressure" in head
- Nausea or vomiting
- Balance problems or dizziness
- Fatigue or feeling tired
- Blurry or double vision
- Sensitivity to light or noise
- Numbness or tingling
- Does not "feel right"

#### Emotional

- Irritable
- Sad
- More emotional than usual
- Nervous

#### Sleep\*

- Drowsy
- Sleeps *less* than usual
- Sleeps *more* than usual

*\*Only ask about sleep symptoms if the injury occurred on a prior day.*

To download this fact sheet in Spanish, please visit: [www.cdc.gov/HEADSUP](http://www.cdc.gov/HEADSUP). Para obtener una copia electrónica de esta hoja de información en español, por favor visite: [www.cdc.gov/HEADSUP](http://www.cdc.gov/HEADSUP)  
January 2021



## Danger Signs

Be alert for symptoms that worsen over time. Your child or teen should be seen in an emergency department right away if she or he has one or more of these danger signs:

- One pupil (the black part in the middle of the eye) larger than the other
- Drowsiness or cannot be awakened
- A headache that gets worse and does not go away
- Weakness, numbness, or decreased coordination
- Repeated vomiting or nausea
- Slurred speech
- Convulsions or seizures
- Difficulty recognizing people or places
- Increasing confusion, restlessness, or agitation
- Unusual behavior
- Loss of consciousness (even a brief loss of consciousness should be taken seriously)

Children and teens with a suspected concussion should **NEVER** return to sports or recreation activities on the same day the injury occurred.

They should delay returning to their activities until a healthcare provider experienced in evaluating for concussion says it's OK to return to play. This means, until permitted, not returning to:

- Physical Education (PE) class
- Sports practices or games
- Physical activity at recess

### What should I do if my child or teen has a concussion?

**1. Seek medical attention right away.**

A healthcare provider experienced in evaluating for concussion can determine how serious the concussion is and when it is safe for your child or teen to return to normal activities, including physical activity and school (concentration and learning activities).

**2. Help them take time to get better.**

If your child or teen has a concussion, her or his brain needs time to heal. Your child or teen may need to limit activities while s/he is recovering from a concussion. Exercising or activities that involve a lot of concentration, such as studying, working on the computer, or playing video games may cause concussion symptoms (such as headache or tiredness) to reappear or get worse. After a concussion, physical and cognitive activities—such as concentration and learning—should be carefully managed and monitored by a healthcare provider.

**3. Talk to your child or teen about how they are feeling.**

Your child may feel frustrated, sad, and even angry because s/he cannot return to recreation and sports right away, or cannot keep up with schoolwork. Your child may also feel isolated from peers and social networks. Talk often with your child about these issues and offer your support and encouragement.

To learn more, go to [www.cdc.gov/HEADSUP](http://www.cdc.gov/HEADSUP) or call 1.800.CDC.INFO

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### How can I help my child return to school safely after a concussion?

Most children can return to school within a few days. Help your child or teen get needed support when returning to school after a concussion. Talk with your child's teachers, school nurse, coach, speech-language pathologist, or counselor about your child's concussion and symptoms.

Your child's or teen's healthcare provider can use CDC's Letter to Schools to provide strategies to help the school set up any needed supports.

As your child's symptoms decrease, the extra help or support can be removed gradually. Children and teens who return to school after a concussion may need to:

- Take rest breaks as needed
- Spend fewer hours at school
- Be given more time to take tests or complete assignments
- Receive help with schoolwork
- Reduce time spent reading, writing, or on the computer
- Sit out of physical activities, such as recess, PE, and sports until approved by a healthcare provider
- Complete fewer assignments
- Avoid noisy and over-stimulating environments



