

Communication with Doctors

Use the links below to jump to a specific resource.

The Guideline: Center for Disease Prevention and Control Guideline on the Diagnosis and Management of Mild Traumatic Brain Injury in Children

JAMA Pediatrics online September 2018 and CDC's five key recommendations from the guideline. Newest guideline for physicians

CDC mTBI Pediatric Guideline Supplemental Documents

- **CDC Pediatric mTBI Diagnosis Recommendations at a Glance:** an overview of all the diagnostic recommendations from the pediatric guideline
- **CDC Pediatric Prognostic Recommendations at a Glance:** an overview of all the prognostic recommendations for physicians
- **CDC Management and Treatment at a Glance:** an overview of the management and treatment recommendations for physicians

Concussion Management Protocol Recommendation

2 visit minimum concussion protocol with information on management, patient education, referrals, and ongoing monitoring

CDC Return to School Letter

This letter contains useful information on the student's symptoms and recommended accommodations. We recommend you send it home to the family to give to the doctor so he/she can fill it in and return it to the school



CENTERS FOR DISEASE CONTROL AND PREVENTION GUIDELINE ON THE DIAGNOSIS AND MANAGEMENT OF MILD TRAUMATIC BRAIN INJURY AMONG CHILDREN

FULL REPORT

★ <https://jamanetwork.com/journals/jamapediatrics/article-abstract/2698456>

Offering 19 sets of clinical recommendations that cover diagnosis, prognosis, and management and treatment, the CDC Pediatric mTBI Guideline is applicable to healthcare providers in all practice settings. The CDC Pediatric mTBI Guideline outlines specific actions healthcare providers can take to help young patients and their parents/caregivers, including five key practice-changing recommendations.

5 KEY RECOMMENDATIONS

1. Do not routinely image pediatric patients to diagnose mTBI.
2. Use validated, age-appropriate symptom scales to diagnose mTBI.
3. Assess for risk factors for prolonged recovery, including history of mTBI or other brain injury, severe symptom presentation immediately after the injury, and personal characteristics and family history (such as learning difficulties and family and social stressors.)
4. Provide patients and their parents/caregivers with instructions on returning to activity customized to their symptoms.
5. Counsel patients and their parents/caregivers to return gradually to non-sports activities after no more than a 2–3 days of rest.



Diagnostic Recommendations



CDC HEADS UP
SAFE BRAIN. STRONGER FUTURE.

This handout for healthcare providers describes diagnosis-related recommendations contained in the CDC Pediatric mTBI Guideline.



GOAL OF THE CDC mTBI GUIDELINE

The goal of the CDC Pediatric Mild Traumatic Brain Injury (mTBI) Guideline is to help healthcare providers take action to improve the health of their pediatric patients with mTBI. To do this, the Guideline consists of 19 clinical recommendations that cover diagnosis, prognosis, and management and treatment. These recommendations are applicable to healthcare providers working in: inpatient, emergency, primary, and outpatient care settings.

The Guideline was developed through a rigorous process guided by the American Academy of Neurology methodology and 2010 National Academy of Sciences methodology for the development of evidence-based guidelines. An extensive review of scientific literature, spanning 25 years of research, formed the basis of the Guideline.

mTBI in children

Childrens' developing brains are more vulnerable to mTBI because:



Their axons are not as well-myelinated.



They are more susceptible to chemical and metabolic changes.

RECOMMENDATIONS FOR THE DIAGNOSIS OF mTBI

Six sets of diagnostic recommendations are included in the Guideline. These recommendations focus on:



Neuroimaging



Neuropsychological tools



Serum Biomarkers

Diagnostic Recommendations

NEUROIMAGING

Computed Tomography (CT)

Clinical evaluation of a child with possible mTBI includes balancing the likelihood of potentially devastating complications of a more severe injury against the risks associated with a head CT.

- Healthcare providers **should not** routinely obtain a head CT for diagnostic purposes in children with mTBI.
- Healthcare providers **should** use validated clinical decision rules to identify children with mTBI at low risk for intracranial injury (ICI), in whom a head CT is not indicated, as well as children who may be at higher risk for clinically important ICI, and therefore may warrant a head CT. Existing decision rules combine a variety of factors that, when assessed together, may increase the risk for more serious injury. Such risk factors include the following:
 - Age < 2 years old
 - Loss of consciousness
 - Severe mechanism of injury
 - Vomiting
 - Amnesia
 - Clinical suspicion for skull fracture
 - Severe or worsening headache
 - Nonfrontal scalp hematoma
 - Glasgow Coma Score < 15
- For children diagnosed with mTBI, healthcare providers **should** discuss the risk of a pediatric head CT in the context of risk factors for ICI with the patient and his/her family.



USE VALIDATED CLINICAL DECISION RULES TO IDENTIFY ICI

It is critical to rule out ICI while avoiding unnecessary risks related to exposure from a head CT. Strong clinical evidence indicates that use of clinical decision rules are effective in identifying children at low risk for ICI.

Magnetic Resonance Imaging (MRI)

There is currently insufficient evidence to recommend the use of brain MRI in the diagnosis of mTBI in children.

- Healthcare providers **should not** routinely use MRI in the acute evaluation of cases of suspected or diagnosed mTBI.

Single Photon Emission Computed Tomography (SPECT)

Insufficient evidence currently exists to recommend the use of SPECT in the diagnosis of mTBI in children.

- Healthcare providers **should not** use SPECT in the acute evaluation of cases of suspected or diagnosed mTBI.

Skull X-rays

CT is better at detecting intracranial injuries, and in the instances where CT is not available, validated clinical decision rules are better than skull X-rays when screening patients with increased risk for ICI.

- Skull X-rays **should not** be used in the diagnosis of pediatric mTBI.
- Skull X-rays **should not** be used in the screening for ICI.

Diagnostic Recommendations



EXAMPLES OF VALIDATED SCALES INCLUDE, BUT AREN'T LIMITED TO:

- Post-Concussion Symptom Scale
- Health and Behavior Inventory
- Post-Concussion Symptom Inventory
- Acute Concussion Evaluation

NEUROPSYCHOLOGICAL TOOLS

Symptom Scales

There are several validated tools that can be applied quickly and inexpensively.

- Healthcare providers **should** use an age-appropriate, validated symptom rating scale as a component of the diagnostic evaluation in children presenting with acute mTBI.

Computerized Cognitive Testing

There is insufficient evidence to determine whether baseline testing in children better identifies mTBI as compared to post-injury scores alone.

- Healthcare providers **may** use validated, age-appropriate computerized cognitive testing in the acute period of injury as a component of the diagnosis of mTBI.

Standardized Assessment of Concussion (SAC)

There is insufficient evidence to support the use of the SAC in the diagnosis of children with mTBI.

SERUM BIOMARKERS

Serum Biomarkers

There is insufficient evidence to currently recommend any of the studied biomarkers for the diagnosis of mTBI in children.

- Healthcare providers **should not** perform these tests outside of a research setting at this time for the diagnosis of children with mTBI.



► Take action to improve the health of your young patients with mTBI.

To view all 19 sets of recommendations, including those that cover prognosis and management/treatment, and to learn more about the CDC Pediatric mTBI Guideline, visit www.cdc.gov/HEADSUP.

Prognostic Recommendations

This handout for healthcare providers describes prognosis-related recommendations contained in the CDC Pediatric mTBI Guideline.



CDC HEADS UP
SAFE BRAIN. STRONGER FUTURE.



GOAL OF THE CDC mTBI GUIDELINE

The goal of the CDC Pediatric Mild Traumatic Brain Injury (mTBI) Guideline is to help healthcare providers take action to improve the health of their pediatric patients with mTBI. To do this, the Guideline consists of 19 clinical recommendations that cover diagnosis, prognosis, and management and treatment. These recommendations are applicable to healthcare providers working in: inpatient, emergency, primary, and outpatient care settings.

The Guideline was developed through a rigorous process guided by the American Academy of Neurology methodology and 2010 National Academy of Sciences methodology for the development of evidence-based guidelines. An extensive review of scientific literature, spanning 25 years of research, formed the basis of the Guideline.

mTBI in children

Symptoms of mTBI generally fall into four categories:

- Somatic
- Cognitive
- Mood/Affective
- Sleep

Symptom resolution:

30%

Experience symptoms
one month post-injury

10%

Experience symptoms
three months post-injury

5%

Experience symptoms
one year post-injury

RECOMMENDATIONS FOR THE PROGNOSIS OF mTBI

Five sets of prognostic recommendations are included in the Guideline. These recommendations focus on:



Counseling patients
on prognosis



Evaluating for
premorbid conditions



Assessing for
risk factors



Use of tools for
predicting prognosis



Interventions for
poor prognosis

Prognostic Recommendations

GENERAL HEALTHCARE PROVIDER COUNSELING OF PROGNOSIS

Evidence suggests education and clear communication from healthcare providers can optimize outcomes.

- Healthcare providers **should** counsel patients and families that the large majority (70-80%) of children with mTBI do not show significant difficulties that last more than 1-3 months post-injury.
- Healthcare providers **should** counsel patients and families that although some factors predict an increased or decreased risk for prolonged symptoms, each child's recovery from mTBI is unique and will follow its own trajectory.



PROGNOSIS RELATED TO PREMORBID CONDITIONS

There is an increased risk of delayed recovery or prolonged symptoms associated with certain premorbid conditions in children with mTBI.

- Healthcare providers **should** assess the premorbid history of children either prior to an injury, as a part of pre-participation athletic examinations, or as soon as possible post-injury in children with mTBI, to assist in determining prognosis.
- Healthcare providers **should** counsel children and families completing pre-participation athletic examinations, and children with mTBI and their families, that recovery from mTBI might be delayed in those with:
 - Premorbid histories of mTBI
 - Learning difficulties
 - Lower cognitive ability (for children with an intracranial lesion)
 - Increased pre-injury symptoms (such as headache disorders)
 - Neurological or psychiatric disorder
 - Family and social stressors

ASSESSMENT OF CUMULATIVE RISK FACTORS AND PROGNOSIS

Evidence indicates that a variety of demographic and injury-related factors predict outcomes in pediatric mTBI.

- Healthcare providers **should** screen for a variety of known risk factors for persistent symptoms in children with mTBI.
- Healthcare providers **may** use validated prediction rules, which combine information about multiple risk factors for persistent symptoms, to provide prognostic counseling to children with mTBI evaluated in emergency department settings.

FACTORS ASSOCIATED WITH POOR PROGNOSIS:

- Older children or adolescents
- Children of Hispanic ethnicity
- Children from a lower socioeconomic status
- Children with more severe presentations of mTBI (including those associated with an intracranial injury)
- Children who report a higher level of acute postconcussion symptoms
- Children with a neurological or psychiatric disorder
- Children with learning difficulties
- Children with family and social stressors

Prognostic Recommendations



EXAMPLES OF VALIDATED SCALES INCLUDE, BUT AREN'T LIMITED TO:

- Post-Concussion Symptom Scale
- Health and Behavior Inventory
- Post-Concussion Symptom Inventory
- Accute concussion Evaluation

ASSESSMENT TOOLS AND PROGNOSIS

Healthcare providers can more effectively counsel patients with mTBI when they have assessed risk factors for outcomes and recovery. However, there is no single assessment tool to predict outcomes.

- Healthcare providers **should** use a combination of tools to assess recovery in children with mTBI.
- Healthcare providers **should** use validated symptom scales to assess recovery in children with mTBI.
- Healthcare providers **may** use validated cognitive testing (including measures of reaction time) to assess recovery in children with mTBI.
- Healthcare providers **may** use balance testing to assess recovery in adolescent athletes with mTBI.



INTERVENTIONS FOR mTBI WITH POOR PROGNOSIS

While most symptoms of mTBI resolve within 1-3 months, some children are at risk for persistent symptoms or delayed recovery. Children who are at higher risk for delayed recovery are more likely to need further intervention.

- Healthcare providers **should** monitor children with mTBI who are determined to be at high risk for persistent symptoms based on premorbid history, demographics, or injury characteristics.
- For children with mTBI whose symptoms do not resolve as expected with standard care (i.e., after 4-6 weeks), healthcare providers **should** provide or refer for appropriate assessments or interventions.

► Take action to improve the health of your young patients with mTBI.

To view all 19 sets of recommendations, including those that cover diagnosis and management and treatment, and to learn more about the CDC Pediatric mTBI Guideline, visit www.cdc.gov/HEADSUP.

Management and Treatment Recommendations



CDC HEADS UP
SAFE BRAIN. STRONGER FUTURE.

This handout for healthcare providers provides an overview of the management and treatment-related recommendations contained in the CDC Pediatric mTBI Guideline.



GOAL OF THE CDC mTBI GUIDELINE

The goal of the CDC Pediatric Mild Traumatic Brain Injury (mTBI) Guideline is to help healthcare providers take action to improve the health of their pediatric patients with mTBI. To do this, the Guideline consists of 19 clinical recommendations that cover diagnosis, prognosis, and management and treatment. These recommendations are applicable to healthcare providers working in: inpatient, emergency, primary, and outpatient care settings.

The Guideline was developed through a rigorous process guided by the American Academy of Neurology methodology and 2010 National Academy of Sciences methodology for the development of evidence-based guidelines. An extensive review of scientific literature, spanning 25 years of research, formed the basis of the Guideline.

mTBI in children

While most have a good recovery, some children experience both acute and long-term problems that affect them:



Physically



Cognitively



Psychologically

RECOMMENDATIONS FOR TREATMENT AND MANAGEMENT OF mTBI

Eight sets of management and treatment recommendations are included in the Guideline. These recommendations focus on:



General areas of treatment for patients and families



Symptom and problem-specific treatments

Management and Treatment Recommendations



Counsel patients to return gradually to non-sports activities after no more than 2-3 days of rest.

GENERAL AREAS OF TREATMENT FOR PATIENTS AND FAMILIES

Health outcomes can generally be optimized through patient education and behavior modification. In addition, evidence suggests that rest, or reduction in cognitive and physical activity, is beneficial immediately following mTBI. This should be followed shortly after the injury with a gradual return to activity.

Patient and Family Education and Reassurance

- In providing education and reassurance to the family, the healthcare provider **should** include the following information:
 - Warning signs indicating a more serious injury
 - Expected course of symptoms and recovery
 - Instructions on monitoring post-concussive symptoms
 - Prevention of further injury
 - Management of cognitive and physical activity, or rest
 - Instructions regarding return to school and return to play or recreation
 - Clear healthcare provider follow-up instructions from a healthcare provider

Cognitive and Physical Rest and Aerobic Treatment

Collaboration among healthcare providers, schools, and families should be coordinated to gradually adjust interventions and return the child to full participation without worsening symptoms.

- Healthcare providers **should** counsel patients to observe more restrictive physical and cognitive activity during the first several days following mTBI in children.
- Following these first several days, healthcare providers **should** counsel patients and families to resume a gradual schedule of activity that does not exacerbate symptoms, with close monitoring of symptom expression (number, severity).
- Following the successful resumption of a gradually increased schedule of activity, healthcare providers **should** offer an active rehabilitation program of progressive reintroduction of noncontact aerobic activity that does not exacerbate symptoms, with close monitoring of symptom expression (number, severity).
- Healthcare providers **should** counsel patients to return to full activity when they return to premorbid performance if they have remained symptom-free at rest, and with increasing levels of physical exertion.

Return to school and play plans can be found at www.cdc.gov/HEADSUP.

Management and Treatment Recommendations

Psychosocial and Emotional Support

Evidence suggests that social support (both tangible help and emotional involvement) contributes to healthy behaviors, and improved overall quality of life.

- Healthcare providers **may** assess the extent and types of social support (e.g., emotional, informational, instrumental, appraisal) available for children with mTBI, and emphasize social support as a key element in the education of caregivers and educators.

Return to School

- To assist children returning to school following mTBI, medical and school-based teams **should** counsel the student and family regarding the process of gradually increasing the duration and intensity of academic activities as tolerated, with the goal of increasing participation without significantly exacerbating symptoms.
- Return to school protocols **should** be customized based on the severity of postconcussion symptoms in children with mTBI as determined jointly by medical and school-based teams.
- For any student with prolonged symptoms that interfere with academic performance, school-based teams **should** assess the educational needs of that student and determine the student's need for additional educational supports, including those described under pertinent federal statutes.
- Postconcussion symptoms and academic progress in school **should** be monitored collaboratively by the student, family, healthcare provider, and school teams, who jointly determine which modifications or accommodations are needed to maintain an academic workload without significantly exacerbating symptoms.
- The provision of educational supports **should** be monitored and adjusted on an ongoing basis by the school-based team until the student's academic performance has returned to pre-injury levels.
- For students who demonstrate prolonged symptoms and academic difficulties despite an active treatment approach, healthcare providers **should** refer the child for a formal evaluation by a specialist in pediatric mTBI.

70 - 80%

of children with mTBI will demonstrate functional recovery by 1-3 months.



Management and Treatment Recommendations



SYMPTOM OR PROBLEM-SPECIFIC TREATMENT AND MANAGEMENT

Post-traumatic Headache Treatment and Management

Painful headaches are one of the most common symptoms in children after mTBI and may require intervention.

- Healthcare providers in the emergency department **should** clinically observe and consider obtaining a head CT in children presenting with a severe and worsening headache, along with other symptoms or risk factors, following mTBI to evaluate for ICI requiring further management in accordance with validated clinical decision making rules.
- Children undergoing observation periods for headache with acutely-worsening symptoms **should** undergo emergent neuroimaging.
- Healthcare providers and caregivers **should** offer non-narcotic analgesia to children with a painful headache following acute mTBI, but also provide counseling to the family regarding the risks of analgesic overuse, including a rebound headache.
- There is insufficient evidence to recommend the administration of 3% hypertonic saline as a treatment for an acute headache following mTBI in children. Healthcare providers **should not** administer this medication to children with mTBI for treatment of symptoms outside of a research setting at this time.
- Chronic headache following mTBI is likely to be multifactorial; therefore, healthcare providers **should** refer children with chronic headache after mTBI for multidisciplinary evaluation and treatment, with consideration of analgesic overuse as a contributory factor.

Healthcare providers should identify and tailor treatment plans/referrals to address:

- **Acutely worsening headache:** consider neuroimaging
- **Worsening sleep problems:** sleep hygiene, sleep specialist
- **Chronic headache:** nonopioid analgesia (monitor for overuse), multidisciplinary evaluation
- **Cognitive impairment:** treatment directed at etiology, neuropsychological evaluation
- **Vestibulo-ocular dysfunction:** vestibular rehabilitation
- **Emotional dysfunction:** psychotherapeutic evaluation and treatment

Vestibulo-ocular Motor Dysfunction

Dizziness is another potentially debilitating symptom of mTBI, and limited evidence suggests that early vestibular physical therapy may benefit patients experiencing dizziness.

- Healthcare providers **may** refer children with subjective or objective evidence of persistent vestibulo-ocular motor dysfunction following mTBI to a program of vestibular rehabilitation.

Management and Treatment Recommendations

Sleep Treatment and Management

Sleep disturbances after mTBI are common and may exacerbate ongoing problems. Adequate sleep has been shown to improve overall health and should be an important part of treatment for children with mTBI.

- Healthcare providers **should** provide guidance on proper sleep hygiene methods to facilitate recovery from pediatric mTBI.
- If sleep problems emerge or continue, despite appropriate sleep hygiene measures, healthcare providers **may** refer children with mTBI to a sleep disorder specialist for further assessment.



Cognitive Impairment Treatment and Management

Problems with attention, memory and learning, response speed, and other cognitive impairment can occur following mTBI. These disturbances can result in significant problems with learning in school, or social interactions.

- Healthcare providers **should** attempt to determine the etiology of cognitive dysfunction within the context of other mTBI symptoms.
- Healthcare providers **should** recommend treatment for cognitive dysfunction that reflects its presumed etiology.
- Healthcare providers **may** refer children with persisting complaints related to cognitive function for a formal neuropsychological evaluation to help determine etiology, and to recommend targeted treatment.



► Take action to improve the health of your young patients with mTBI.

To view all 19 sets of recommendations, including those that cover diagnosis and prognosis, and to learn more about the CDC Pediatric mTBI Guideline, visit www.cdc.gov/HEADSUP.



CONCUSSION MANAGEMENT PROTOCOL

Recommendation: 2 Visit Minimum

INITIAL VISIT

Outcomes are better if educational materials are given at the first visit.

SYMPTOM EVALUATION AND PATIENT EDUCATION:

- ACE - Acute Concussion Evaluation (*Physician/Clinician Office Version*)
- A Symptom Scale (*Age-appropriate version*)
- A Symptom Scale (*Parent/Adult Patient - fill out in office*)
- A Symptom Scale (*Parent/Adult Patient - take home*)
- ACE Care Plan (Return to School or Work Version)
- CDC Return to School Letter
- When Concussion Symptoms Are Not Going Away (*Age-appropriate version*)
- Any other educational materials or Symptom Tracker as needed

➤ **Send home** an additional parent or adult version of a symptom scale to track symptoms over the next 4 weeks or until next appointment - this helps to understand what symptoms/behaviors to look for. **Send home** a letter to the school or work with accommodations and other recommendations. Research indicates that supports are more likely to be implemented if recommended by the health care professional.

➤ **Cognitive Rest:** Research shows only **2-3 days** of strict cognitive rest is helpful. After that, return to activity as tolerated is recommended. **Safe exercise** (treadmill, stationary bicycle) that only mildly increases symptom level may be helpful in recovery. However, athletes should **not return to sports until all symptoms have cleared**.

➤ With concussion diagnosis, **SCHEDULE a follow up visit within 4 weeks. If any symptoms or new behaviors since injury are present, proceed with 2nd visit.** Patient brings back completed take-home symptom scale to next visit. Most symptoms will clear by 4 weeks, however, they should be addressed earlier as needed.

2ND VISIT (BY 4 WEEKS)

Refer to a symptom-specific specialist when possible.

- Specialized Concussion Treatment Center
- Brain Trauma Rehabilitation Center
- Sports Medicine
- Neurologist
- Neuro-ophthalmologist
- Physical Therapist
- Occupational Therapist
- Speech Language Pathologist
- Sleep specialist
- Neuropsychologist
- Psychologist
- TEIS if child is under 3 years old
- TEIS Extended Option - If already receiving services therapy can continue until the school year after 5th birthday.
- School/School district (3 years and older if not already enrolled in TEIS)

YEARLY CHECK-UPS

For all patients with no known history of brain injury, screen yearly for prior history.

Over the last year, ask about:

- Any residual concussion symptoms
- Any changes in school or work performance
 - Drop in grades, difficulty with new learning, falling behind with work, etc.
- Any physical changes or challenges (balance, ocular, pain)
- Any cognitive changes or challenges, for example in memory or attention
 - Forgetting homework or books at home. Difficulty paying attention in a work environment.
- Substance Use
- Chronic pain
- Relationships /Friendships
- Any new injuries
- Any behavior/mood changes

Refer if needed

ADDITIONAL RESOURCES

- **Traumatic Brain Injury Toolkit for Healthcare Providers:** Includes many useful tools and educational handouts, including those mentioned in this protocol.
<https://www.tndisability.org/brain-toolkits>
- **TBI Toolkit for Survivors, Families & Caregivers:**
<https://www.tndisability.org/brain-toolkits>
- **Research Support for this Concussion Management Protocol:**
<https://www.tndisability.org/primary-emergency-care-providers>
- **Brain Links Website:** <https://www.tndisability.org/brain>

THINGS TO WATCH FOR OVER TIME

- Headaches
- Changes in sleep patterns
- Fatigue
- Changes in vision
- Balance, coordination changes, dizziness
- Mood swings, getting mad easily
- Changes in personality
- Not feeling like themselves
- Trouble with attention and thinking
- Memory problems, especially short term
- Depression, anxiety
- Difficulty handling stress
- Inappropriate behavior
- Grades dropping, falling behind in class
- Changes in work performance
- Overuse/misuse of legal or illegal substances
- Chronic pain
- Loss of friendships; difficulty with relationships



Returning to School After a Concussion



CDC HEADS UP
SAFE BRAIN. STRONGER FUTURE.

DEAR SCHOOL STAFF:

This letter offers input from a healthcare provider with experience in treating concussion, a type of traumatic brain injury. This letter was created to help school professionals and parents support students returning to school after a concussion. You can use these recommendations to make decisions about support for your student based on his or her specific needs. This letter is not intended to create a 504 Plan or an IEP unless school professionals determine that one is needed. Most students will only need short-term support as they recover from a concussion. A strong relationship between the healthcare provider, the school, and the parents will help your student recover and return to school.

_____ was seen for a concussion on _____
Student Name Date
in _____ office or clinic.
Healthcare Provider's Name

The student is currently reporting the following symptoms:



PHYSICAL

- ☐ Bothered by light or noise
- ☐ Dizziness or balance problems
- ☐ Feeling tired, no energy
- ☐ Headaches
- ☐ Nausea or vomiting
- ☐ Vision problems



THINKING OR REMEMBERING

- ☐ Attention or concentration problems
- ☐ Feeling slowed down
- ☐ Foggy or groggy
- ☐ Problems with short- or long-term memory
- ☐ Trouble thinking clearly



SOCIAL OR EMOTIONAL

- ☐ Anxiety or nervousness
- ☐ Irritability or easily angered
- ☐ Feeling more emotional
- ☐ Sadness



SLEEP

- ☐ Sleeping less than usual
- ☐ Sleeping more than usual
- ☐ Trouble falling asleep

The student also reported these symptoms:

RETURNING TO SCHOOL

Based on the student's current symptoms, I recommend that the student:

- ☐ Be permitted to return to school and activities while school professionals closely monitor the student. School professionals should observe and check in with the student for the first two weeks, and note if symptoms worsen. If symptoms do not worsen during an activity, then this activity is OK for the student. If symptoms worsen, the student should cut back on time spent engaging in that activity, and may need some short-term support at school. Tell the student to update his or her teachers and school counselor if symptoms worsen.
- ☐ Is excused from school for _____ days.
- ☐ Return to school with the following changes until his or her symptoms improve.

(NOTE: Making short-term changes to a student's daily school activities can help him or her return to a regular routine more quickly. As the student begins to feel better, you can slowly remove these changes.)

Based on the student's symptoms, please make the short-term changes checked below:

- | | |
|---|--|
| ☐ No physical activity during recess | ☐ Allow for a quiet place to take rest breaks throughout the day |
| ☐ No physical education (PE) class | ☐ Lessen the amount of screen time for the student, such as on computers, tablets, etc. |
| ☐ No after school sports | ☐ Give ibuprofen or acetaminophen to help with headaches (as needed) |
| ☐ Shorten school day | ☐ Allow the student to wear sunglasses, earplugs, or headphones if bothered by light or noise |
| ☐ Later school start time | ☐ Other: _____ |
| ☐ Reduce the amount of homework | |
| ☐ Postpone classroom tests or standardized testing | |
| ☐ Provide extended time to complete school work, homework, or take tests | |
| ☐ Provide written notes for school lessons and assignments (when possible) | |

Most children with a concussion feel better within a couple of weeks. However, for some, symptoms can last for a month or longer. **If there are any symptoms that concern you, or are getting worse, notify the student's parents that the student should be seen by a healthcare provider as soon as possible.**

► For information on helping students return to school safely after a concussion, visit www.cdc.gov/HEADSUP.

Healthcare Provider's Name (printed)

Healthcare Provider's Signature

Date

For additional questions, you may reach me at: _____



Thank You!

We're here to help

Our mission is to bring together professionals to recognize the far-reaching and unique nature of brain injury and to improve services for survivors. If we can help you, please feel free to reach out!



Contact us:

tbi@tndisability.org

Check out our website:

www.tndisability.org/brain

Follow us on social media:



We want to hear from you!



Complete our short survey to let us know how we're doing.

