Peterborough Victoria Northumberland and Clarington Catholic District School Board

Ref: AP324
APPENDIX C

Concussion – Return to Learn/Return to Physical Activity Plan

STUDENT NAME: _____
(Please print)

Date of Birth: ____ / ____ / ____ **O.E.N. #** _____
mm dd year

The Return to Learn/Return to Physical Activity Plan is a combined approach.
Each step must take a minimum of 24 hours

Step 1 – Return to Learn/Return to Physical Activity

- *Completed at home.*
- *Cognitive Rest – includes limiting activities that require concentration and attention (e.g., reading, texting, television, computer, video/electronic games).*
- *Physical Rest – includes restricting recreational/leisure and competitive physical activities.*

☐ My child/ward has completed Step 1 of the Return to Learn/Return to Physical Activity Plan (cognitive and physical rest at home) and his/her **symptoms have shown improvement**. My child/ward will proceed to Step 2a – Return to Learn/Return to Physical Activity.

☐ My child/ward has completed Step 1 of the Return to Learn/Return to Physical Activity Plan (cognitive and physical rest at home) and is **symptom free**. My child/ward will proceed directly to Step 2b – Return to Learn/Return to Physical Activity.

Parent/Guardian Name: _____
(Please print)

Signature: _____ Date: _____

Medical Doctor/Nurse Practitioner Name: _____
(Please print)

Signature: _____ Date: _____

Comments:

_____

_____

_____

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If at any time during the following steps symptoms return, please refer to the "Return of Symptoms" section on page 4 of this form.

STUDENT NAME: _____
(Please print)

Step 2a – Return to Learn/Return to Physical Activity (with symptoms)

- *Student returns to school.*
- *Requires individualized classroom strategies and/or approaches which gradually increase cognitive activity.*
- *Physical rest – includes restricting recreational/leisure and competitive physical activities.*

☐ My child/ward, has been receiving individualized classroom strategies and/or approaches and is now **symptom free**. My child/ward will proceed to Step 2b – Return to Learn/Return to Physical Activity.

Parent/Guardian Name: _____
(Please print)

Signature: _____ Date: _____

Comments:

_____

_____

_____

Step 2b – Return to Learn/Return to Physical Activity (symptom free)

- *Student returns to regular learning activities at school.*
- *Student can participate in individual light aerobic physical activity only.*

☐ My child/ward is symptom free after participating in light aerobic physical activity. My child/ward will proceed to Step 3 – Return to Learn/Return to Physical Activity.

☐ This form will be returned to the teacher to record progress through Steps 3 and 4.

Parent/Guardian Name: _____
(Please print)

Signature: _____ Date: _____

Comments:

_____

_____

_____

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STUDENT NAME: _____
(Please print)

Step 3 – Return to Learn/Return to Physical Activity
- *Student continues with regular learning activities.*
- *Student may begin individual sport-specific physical activity only.*

Step 4 – Return to Learn/Return to Physical Activity
- *Student continues with regular learning activities.*
- *Student may begin activities where there is no body contact (e.g., dance, badminton); light resistance/weight training; non-contact practice; and non-contact sport-specific drills.*

☐ Student has successfully completed Steps 3 and 4.

☐ This form will be returned to parent/guardian to obtain medical doctor/nurse practitioner diagnosis and signature.

Principal Name: _____
(Please print)

Signature: _____ Date: _____

Medical Examination

I, _____ have examined _____
(Medical doctor/nurse practitioner name) (Student's name)

and confirm he/she continues to be symptom free and is able to return to regular physical education class/ intramural activities/interschool activities in non-contact sports and full training/practices for contact sports.

Signature: _____ Date: _____

Comments:

_____

_____

_____

Step 5 – Return to Learn/Return to Physical Activity
- *Student continues with regular learning activities.*
- *Student may resume regular physical education/intramural activities/interschool activities in non-contact sports and full training/practices for contact sports.*

Step 6 – Return to Learn/Return to Physical Activity
- *Student continues with regular learning activities.*
- *Student may resume full participation in contact sports with no restrictions.*

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STUDENT NAME: _____
(Please print)

Return of Symptoms

☐ My child/ward has experienced a return of concussion signs and/or symptoms and has been examined by a medical doctor/nurse practitioner, who has advised a return to:

Step _____ of the Return to Learn/Return to Physical Activity Plan

Parent/Guardian Name: _____
(Please print)

Signature: _____ Date: _____

Comments:

_____

_____

_____

Information Collection Authorization: The personal information contained on this form has been collected in accordance with the Municipal Freedom of Information and Protection of Privacy Act, and Policy and Program Memorandum 158, titled School Board Policies on Concussion.

USER: PRINCIPAL, TEACHERS, SPECIAL EDUCATION RESOURCE TEACHER, COACHES

ORIGINAL: OSR COPIES: 1. PARENT/GUARDIAN/STUDENT, IF OVER THE AGE OF 18