IMMEDIATE AND TEMPORARY ACCOMMODATIONS PLAN (ITAP) FOR TRAUMATIC BRAIN INJURY

Student: _____ DOB _____ ID# _____ School _____Gr._____

TBI sustained on: _____ Date Written Notification Received:_____
Return to School Anticipated: _____Date ITAP completed on: _____ By: _____
List other team members consulted _____
Parent/Guardian Name: _____ Contact _____
Medical Provider Name: _____ Contact _____

A concussion or other brain injury can significantly affect a student's ability to participate in learning by impacting physical, cognitive, emotional, and behavioral functioning. Each student's recovery is unique and may include periods of progress and setbacks. A timely, symptom-based response, including temporary physical, cognitive, and social-emotional accommodations is critical to ensuring safety, supporting recovery, and promoting continued access to education. In accordance with House Bill 3007 (2025) and OAR 581-021-3007 public education providers are required to follow ODE's brain injury procedure and use this Immediate and Temporary Accommodations Plan (ITAP) upon receiving written notification that a student has been diagnosed with a concussion or other brain injury. Plan components may be adjusted or discontinued by the Brain Injury Management Team as needed and must remain in effect until formally revised/discontinued.

Medical Documentation Date: _____ Notes: _____
Abbreviated Day Recommended? Y/N Notes:_____
Related Medication in the Health Room Y/N Notes:_____

The student reports the following signs and symptoms:

(See: ODE's Symptom-Based Accommodation Guide)

PHYSICAL:

☐ Headache or head pressure ☐ Light sensitivity ☐ Sound sensitivity ☐ Smell sensitivity ☐ Fatigue ☐ Dizziness, ☐ Balance problems ☐ Nausea and vomiting ☐ Numbness or Tingling ☐ Ringing in ears ☐ Impaired sleep (more, less, or fragmented) ☐ Blurry or double vision ☐ Trauma associated seizures ☐ Other: _____ ☐ Other_____

COGNITIVE:

☐ Slowed information processing ☐ Difficulty with Attention and concentration ☐ "Brain fog" ☐ Difficulty with memory ☐ Trouble learning new information or retaining it ☐ Unable to follow instruction ☐ Inability to multitask or organize ☐ Difficulty tracking conversations ☐ Feeling "slowed down" ☐ Other: _____ ☐ Other_____

SOCIAL-EMOTIONAL:

☐ Poor emotional regulation ☐ Irritability or quick to anger ☐ Unusual sadness ☐ Decreased motivation, ☐ Anxiety or depression ☐ Post-traumatic stress disorder ☐ Grief ☐ Loss of social skills ☐ Withdrawal from friends and family ☐ Other: _____ ☐ Other_____

Activity Restrictions: Y/N Describe: _____
Medical instructions from Provider or Athletic Trainer for Activity Modification: Y/N Date: _____
Return to full physical activity during school. Y/N Date: _____

Accommodations

(See: ODE's Symptom-Based Accommodation Guide)

PHYSICAL

- ☐ Allow rest breaks with low light and noise at _____
- ☐ Wear sunglasses and/or hat in class, seating away from bright sunlight
- ☐ Allow hearing protection or unplugged, noise-reducing headphones during class
- ☐ Limit screen time by offering assignments by book and paper, when possible.
- ☐ Provide a lunchtime space away from crowded areas.
- ☐ Leave class 5 minutes early or late to avoid crowding in halls
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

COGNITIVE

- ☐ Preferential seating and provide immediate feedback
- ☐ Break down assignments and tests into shorter segments
- ☐ Shorten in-class and homework assignments to key concepts and critical tasks only
- ☐ Reduce or slow down verbal information and check for comprehension
- ☐ Teacher generated class notes and/or recorded lecture
- ☐ Allow extended time to complete coursework, assignments, and tests if requested
- ☐ Stagger testing so that the student only needs to prepare for one exam/quiz per day
- ☐ Alternatives to written output for demonstrating understanding: _____
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

SOCIAL-EMOTIONAL

- ☐ Teacher/staff to provide reassurance about accommodations and workload reduction
- ☐ Permit lunchtime in a quiet space with 1-2 friends
- ☐ Allow student to work with a peer or peer group for selected assignments
- ☐ Give non-verbal cues to stay on task or change behavior
- ☐ Pass to wellness room or counseling center to regroup when upset
- ☐ Utilize an emotional and behavioral support plan
- ☐ Other: _____
- ☐ Other: _____
- ☐ Other: _____

Date of first review (within 5 days of ITAP implementation): _____ Completed Date: _____

Date of next review (no later than two months): _____ Completed Date: _____

Evaluation under ☐ Section 504, or ☐ IDEA initiated? Y / N Date: _____ Eligible Y / N

ITAP shared with parent/guardian and required school staff? Y / N Date: _____

Date Temporary Accommodations Plan Discontinued: _____

Notes: _____

_____

_____

Directions for Completing the ITAP Form

Complete this form in accordance with House Bill 3007 (2025) and OAR 581-021-3007 upon receiving written notification from a qualified health care provider that a student has a concussion or other brain injury. It should be completed promptly and reviewed regularly by the Brain Injury Management Team.

Student Information

- **Student / DOB / ID# / School / Grade:** Enter student's full name, birth date, ID, school, and grade.
- **TBI Sustained On:** Date of injury.
- **Date Written Notification Received:** Date the school received notification from parent/guardian.
- **Return to School Anticipated:** If known, note date.
- **Date ITAP Completed On / By:** Date completed and name of lead staff.
- **Other Team Members Consulted:** List all consulted.
- **Parent/Guardian & Contact** and **Medical Provider & Contact:** Fill in names and best contacts.

Medical Documentation & Initial Needs

- **Medical Documentation Date / Notes:** Enter date and summarize notes.
- **Abbreviated Day Recommended?** Circle **Y** or **N** and explain if "Yes."
- **Related Medication in Health Room?** Circle **Y** or **N** and list medication if applicable.

Signs and Symptoms

- Check all that apply under **Physical**, **Cognitive**, and **Social-Emotional** based on student or provider input.
- Use "Other" lines for symptoms not listed.

Activity Restrictions

- Circle **Y/N** for restrictions, describe if "Yes."
- Note medical instructions for activity modification and date received.
- Record clearance date for full physical activity.

Accommodations

- Check all that apply using ODE's Symptom-Based Accommodation Guide under **Physical, Cognitive,** and **Social-Emotional:**
- Use "Other" lines for additional accommodations.

Review and Follow-Up

- **First Review:** Within 5 school days of implementation.
- **Next Review:** No later than 2 months after implementation.
- **504/IDEA Evaluation:** Indicate Y/N, initiation date, eligibility.
- **ITAP Shared with Parent/Staff:** Circle Y/N, note date.
- **Plan Discontinued:** Date
- Notes: Add any additional notes needed to track implementation and progress of student.

Key Reminders

- The plan must remain in effect until formally revised or discontinued by the Brain Injury Management Team.
- Adjustments must be made as symptoms change—progress may not be linear.
- Keep a copy in the student's record, share with parent/guardian and with all staff responsible for implementation.