Date: [Date]

To: [School Name/Academic Institution]
Attention: [School Nurse/Principal/Section 504 Coordinator]

RE: Post-Concussion Return to Learn Medical Clearance

Student Name: [Student Full Name]
Date of Birth: [DOB]
Date of Injury: [Injury Date]

To whom it may concern,

[Student Name] has been under my care for the management of a concussion. Following a clinical evaluation on [Date of Evaluation], I have determined that the student is now medically cleared to return to full academic activities.

Clearance Status (Select one):

- Return to full academic load without restrictions.
- Return to full academic load with the following temporary accommodations: [List accommodations, e.g., extended time for testing, frequent breaks].

The student is currently:
[ ] Asymptomatic at rest.
[ ] Asymptomatic with cognitive exertion.

Please note that this clearance applies to **academic/classroom activities only**. Clearance for physical education (PE) and competitive sports requires a separate "Return to Play" protocol and further medical documentation.

If the student experiences a recurrence of symptoms (such as headache, dizziness, or confusion) during school hours, they should be permitted to rest, and I should be notified immediately.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]
[Clinic/Medical Facility Name]
[Phone Number]
[License Number]