

**Date:** [Date]

**To:** [School Name / Principal / School Nurse]

**From:** [Physician Name/Clinic Name]

**Patient Name:** [Student Name]

**Date of Birth:** [DOB]

**Date of Injury:** [Date]

To whom it may concern,

[Student Name] has been diagnosed with a concussion. During the recovery period, this student may require temporary academic accommodations to manage symptoms and prevent exacerbation of the injury. Please apply the checked recommendations below:

**Phase 1: Total Rest (Expected duration: [Number] days)**

- No school attendance.
- No homework, testing, or screen time.

**Phase 2: Graduated Return to School**

- Partial school days (half days or specific periods).
- Frequent rest breaks (15 minutes in a quiet area if symptoms arise).
- Extended time for assignments and testing.
- No standardized testing or high-stakes exams.
- Reduced workload (limit homework to [Number] minutes per night).
- Avoidance of bright lights/loud noises (allow sunglasses or earplugs).
- Printed class notes to be provided to the student.

**Physical Activity Restrictions:**

- No Physical Education (PE) classes.
- No recess or contact sports.
- No weight lifting or strenuous exertion.

The student may return to full academic activities once they can tolerate a full day of school without a return of symptoms. A separate clearance letter will be required for return to competitive sports.

**Follow-up Appointment:** [Date/Time]

Sincerely,

[Physician Signature]  
[Physician Name and Credentials]

[Clinic Name]  
[Phone Number]