

**Date:** [Date]

**To:** [School Name] Administration and Teaching Staff

**Subject:** Post-Concussion Return to Learn Authorization

**Student Name:** [Student Full Name]

**Date of Birth:** [DOB]

**Date of Injury:** [Date of Concussion]

To Whom It May Concern,

The above-named student has been evaluated following a concussive injury. They are medically cleared to return to school on [Return Date] under the following academic progression plan:

**Current Phase:**

- Full rest (No school/No homework)
- Gradual return with academic adjustments
- Full return without restrictions

**Required Academic Adjustments (Select all that apply):**

- Shortened school days (e.g., half days or specific periods)
- Frequent rest breaks during the day (e.g., 15 minutes every hour)
- Extended time for assignments and testing
- Reduced workload (e.g., skip non-essential assignments)
- No significant testing or high-stakes exams at this time
- Limited screen time (computers, tablets, smartboards)
- Protection from loud environments (cafeteria, gym, music class)
- Provide printed copies of class notes

**Physical Activity Restrictions:**

The student is strictly prohibited from participating in PE classes, recess, or organized sports until further medical clearance is provided.

**Follow-Up:**

This student will be re-evaluated on [Follow-up Date]. These recommendations may be updated at that time based on symptom resolution.

If you have any questions regarding these medical requirements, please contact my office.

Sincerely,

[Physician Signature]

[Physician Printed Name]

[Medical Clinic/Practice Name]  
[Phone Number]