Date: [Date]

To: [School Name/Academic Administration]
From: [Provider Name, Title]
Clinic: [Neurology Clinic Name]

Patient Name: [Patient Name]
Date of Birth: [Date of Birth]
Date of Evaluation: [Date]

To Whom It May Concern,

[Patient Name] has been under the care of this neurology clinic for management of a concussion/mild traumatic brain injury. Based on today's clinical evaluation, the patient is cleared to return to academic activities as follows:

Current Status:
[ ] Full return to school with no restrictions.
[ ] Full return to school with the temporary accommodations listed below.
[ ] Partial return to school (reduced hours/half days).

Recommended Academic Accommodations (if applicable):
- Allow rest breaks if symptoms (headache, dizziness, fatigue) increase.
- Extended time for tests and assignments.
- Reduced workload (limit homework to essential tasks only).
- Avoidance of high-stimulation environments (noisy cafeterias, music rooms).
- Prefilled notes or use of a laptop to reduce screen/visual strain.

Physical Activity Restrictions:
[ ] No physical education (PE) or contact sports until further notice.
[ ] Limited physical activity as tolerated (no contact).
[ ] Full clearance for physical activity and sports.

This clearance is effective as of [Date]. A follow-up appointment is scheduled for [Date]. Please contact our office at [Phone Number] if you have any questions regarding these recommendations.

Sincerely,

[Signature]

[Provider Name]
[Clinic Name/Address]