Date: [Date]

To: [School Name/School Administrator]

Re: Return to Learn Medical Clearance

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

To Whom It May Concern,

[Student Name] has been under my care for the management of a concussion. Based on my clinical evaluation, the student is cleared to return to school-based academic activities effective [Start Date].

Current Status (Check one):

- Full return to school with no restrictions or accommodations.
- Return to school with the following academic accommodations:

Recommended Accommodations (if applicable):

- Shortened school days (e.g., half-days or specific hours).
- Frequent rest breaks or access to a quiet room as needed.
- Extended time for assignments and testing.
- Reduced workload (e.g., homework limited to 30 minutes per night).
- Exemption from standardized testing or major exams for [Duration].
- Preference seating (away from bright lights or loud noises).
- No physical education (PE) classes or contact sports.

The student should be monitored for the recurrence of symptoms, including headache, dizziness, or cognitive fatigue. If symptoms worsen, the student should be allowed to rest, and I should be notified.

A follow-up appointment is scheduled for [Follow-up Date].

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Practice/Clinic Name]
[Phone Number]