

**Date:** [Date]

**To:** [School Name/Academic Administration]

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

**RE:** Medical Necessity for Academic Accommodations

**Student Name:** [Student Name]

**Date of Birth:** [DOB]

**Date of Injury:** [Date]

To whom it may concern,

[Student Name] has been evaluated at our clinic for a diagnosed concussion. To assist in their recovery and prevent the worsening of symptoms, the following academic accommodations are medically recommended starting [Start Date] through [Expected End Date/Follow-up Date].

**Attendance Recommendations:**

- Full rest (No school attendance)
- Partial attendance (Half-days as tolerated)
- Full attendance with the accommodations listed below

**Academic Accommodations:**

- **Testing:** No standardized testing or high-stakes exams. Provide extended time (1.5x or 2x) for quizzes and tests. Allow testing in a quiet, distraction-free environment.
- **Workload:** Reduce overall homework volume by 50% or more. Extend deadlines for all assignments. Waive non-essential assignments.
- **Environment:** Allow the use of sunglasses or hats indoors for light sensitivity. Provide preferential seating away from loud projectors or bright windows. Allow "rest breaks" in a quiet area (e.g., nurse's office) if symptoms flare.
- **Technology:** Limit screen time (computers, tablets, smartboards). Provide printed copies of notes and assignments.

**Physical Activity Restrictions:**

- No Physical Education (PE) classes.
- No contact sports or recess activities involving risk of head impact.
- No weightlifting or strenuous exertion.

The student will be re-evaluated on [Follow-up Appointment Date] to determine if these restrictions should be modified or lifted.

Sincerely,

[Signature of Healthcare Provider]

[Printed Name and Credentials]

[Phone Number]

[Clinic Stamp]