

**Date:** [Date]

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

**From:** [Provider Name, Title]

**Clinic Name:** [Clinic Name]

**Clinic Phone:** [Phone Number]

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**RE: Return to Learn Medical Clearance**

**Patient Name:** [Patient Name]

**Date of Birth:** [Date of Birth]

**Date of Injury/Diagnosis:** [Date]

To Whom It May Concern,

The above-named student has been evaluated at our clinic following a [Concussion/Medical Illness]. Based on today's evaluation, the student is cleared to return to school under the following conditions:

**Status (Check one):**

- Full return to school with no restrictions.
- Return to school with the temporary academic accommodations listed below.

**Recommended Academic Accommodations (if applicable):**

- Limited screen time (computer, tablet, smartboard).
- Frequent rest breaks during the school day.
- Extended time for assignments and testing.
- Reduced workload or shortened school days.
- Exemption from standardized testing or final exams.
- Avoidance of loud environments (music room, cafeteria, assembly).

**Physical Activity Restrictions:**

- No Physical Education (PE) or recess.
- No contact sports or high-risk activities.
- Full clearance for all physical activities.

This clearance is effective from [Start Date] through [End Date/Follow-up Date]. We will re-evaluate the student on [Date] to determine if further accommodations are necessary.

If you have any questions, please contact our clinic.

Sincerely,

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[Provider Signature]

[Provider Name and Credentials]

[Clinic Stamp/Address]