Date: [Date]

To: [School Name/Principal/School Nurse]

Subject: Graduated Return to Learn Medical Authorization

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

To whom it may concern,

The above-named student has been diagnosed with a concussion. They are currently under my care and require a graduated return to academic activities. Please implement the following checked accommodations to support their recovery:

Phase 1: Home Rest (Initial 24-48 hours)
[ ] No school attendance. Total cognitive rest.

Phase 2: Return to School with Accommodations
[ ] Reduced school days (half days or specific periods).
[ ] Frequent rest breaks during the day (15 minutes in a quiet area).
[ ] No testing or standardized assessments.
[ ] Extended time for assignments and in-class work.
[ ] Reduced workload (essential homework only).
[ ] Provide printed copies of notes or allow a peer note-taker.
[ ] Sensitivity to light/noise: Allow sunglasses and/or earplugs; avoid loud areas like the cafeteria or gym.

Phase 3: Gradual Removal of Accommodations
[ ] Student may resume full school days but requires extra time for tests.
[ ] Student may resume testing once asymptomatic during school hours.

Physical Activity Restrictions:
[ ] **NO** Physical Education (PE) classes.
[ ] **NO** contact sports or high-risk activities (recess/climbing).
[ ] Light aerobic activity only (walking) as tolerated.

This plan will remain in effect until [Follow-up Date] or until the student is cleared by a medical professional. If symptoms worsen during any phase, the student should return to the previous level of activity.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]

[Clinic/Medical Facility Name]
[Phone Number]