

Date: [Date]

To: [School Name / Principal / School Nurse]

Re: Concussion Management Plan for [Student Name]

Date of Birth: [DOB]

Date of Injury: [Date]

To whom it may concern,

[Student Name] has been diagnosed with a concussion. To assist in their recovery, the following "Return to Learn" protocol is recommended starting [Start Date].

1. Academic Status (Check one):

- Complete cognitive rest (No school, no homework, no screen time).
- Gradual return to school with accommodations listed below.
- Full return to school without restrictions.

2. Required Accommodations:

- Shortened school days (e.g., half days or specific hours).
- Frequent rest breaks in a quiet area if symptoms flare up.
- Extended time to complete assignments and tests.
- Reduction in workload (e.g., homework limited to 30 minutes).
- No significant testing or final exams.
- Printed class notes or use of a peer note-taker.
- Avoidance of bright lights, loud noises (e.g., cafeteria, band, shop class).
- Limited screen time (computers, tablets, smart boards).

3. Physical Activity Restrictions:

- No Physical Education (PE) class.
- No recess or contact sports.
- No weightlifting or strenuous activity.

This plan will remain in effect until [Review Date] or until the student is re-evaluated by a healthcare professional.

Sincerely,

[Physician Signature]
[Physician Name, Title]

[Clinic/Hospital Name]
[Phone Number]