

Date: [Date]

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

[School Name]

[School Address]

Re: Concussion Return to School Protocol for [Student Name]

To whom it may concern,

This letter is to confirm that [Student Name] (DOB: [Date of Birth]) was evaluated on [Date] following a concussion sustained on [Injury Date]. Due to the severity of symptoms, an extended medical absence was required. The student is now cleared to begin a graduated return to the classroom effective [Start Date].

To ensure a safe recovery, the following academic accommodations are medically recommended:

- **Reduced Workload:** Postpone all exams, quizzes, and standardized testing until cleared by a physician.
- **Frequent Breaks:** Allow 10-15 minute rest periods in a quiet area if symptoms (headache, dizziness, fatigue) worsen.
- **Shortened School Day:** Start with [Number] hours per day and gradually increase based on symptom tolerance.
- **Environment:** Limit exposure to bright lights, loud noises (music rooms/cafeteria), and excessive screen time.
- **Physical Activity:** No physical education (PE) classes, contact sports, or strenuous recess activities until further notice.

We will re-evaluate [Student Name] on [Follow-up Date] to determine if these restrictions can be lifted. Please notify the parents or my office if the student experiences a significant increase in symptoms during school hours.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[Medical Practice Name]

[Phone Number]