Date: [Date]

To: [School Name/Principal/School Nurse]

Re: Return to School Clearance for [Student Name]

Date of Birth: [DOB]

Date of Injury: [Date]

To Whom It May Concern,

[Student Name] was evaluated at [Hospital/Clinic Name] following a concussion. Based on their current clinical status, the student is cleared to return to school on [Return Date] under the following protocol:

Section 1: Academic Accommodations (Check all that apply)

- [ ] Shortened school days (e.g., half days)
- [ ] Frequent rest breaks or access to a quiet room
- [ ] Extended time for assignments and testing
- [ ] Reduced workload (no new material or heavy homework)
- [ ] Avoidance of bright lights, loud noises, and screen time (computers/tablets)
- [ ] No standardized testing or final exams at this time

Section 2: Physical Activity Restrictions

- **Physical Education (PE):** No participation until further notice.
- **Recess:** Restricted to quiet, supervised areas; no contact play.
- **Sports:** No organized sports, practices, or competitions.

Section 3: Return to Play Protocol

The student must remain symptom-free during full-time academic instruction before beginning a supervised "Return to Play" physical progression.

Section 4: Follow-Up

The student is scheduled for a follow-up evaluation on [Follow-up Date]. Please notify the parents or guardians immediately if the student experiences worsening headaches, dizziness, confusion, or nausea during school hours.

Sincerely,

[Physician Signature]
[Physician Name and Title]

[Medical Facility Name]
[Phone Number]