Date: [Date]

To: [Name of Supervisor, Teacher, or Human Resources]
From: [Physician/Provider Name]
Re: Vision Accommodations for [Patient Name]

To Whom It May Concern,

[Patient Name] is currently under my care for the treatment of a concussion sustained on [Date of Injury]. As a result of this injury, the patient is experiencing vision-related symptoms, including light sensitivity (photophobia), blurred vision, and difficulty with visual tracking and concentration.

To support their recovery and prevent the worsening of symptoms, I recommend the following accommodations be implemented until [End Date or Re-evaluation Date]:

- **Screen Time Limits:** Reduce continuous computer, tablet, or phone use. Recommend a "20-20-20" rule (every 20 minutes, look at something 20 feet away for 20 seconds).
- **Printed Materials:** Provide physical copies of documents to minimize screen glare and digital eye strain.
- **Lighting Adjustments:** Allow the use of sunglasses or tinted lenses indoors, and permit the patient to work in dimmed lighting or away from fluorescent overhead lights.
- **Frequent Breaks:** Allow 5-10 minute "eye rests" in a dark or quiet space if symptoms like headaches or dizziness increase.
- **Font and Contrast:** Allow for increased font sizes and the use of "dark mode" or high-contrast settings on digital devices.
- **Testing/Deadlines:** Provide extended time for reading-heavy tasks or exams to account for slower visual processing speeds.

Please contact my office at [Phone Number] if you require further clarification regarding these medical necessities.

Sincerely,

[Signature]
[Printed Name and Title]
[Medical Facility Name]