

Date: [Date]

To: [School Name/Principal/School Nurse]

Patient Name: [Student Full Name]

Date of Birth: [DOB]

To Whom It May Concern,

The student named above was evaluated on [Date of Evaluation] for a concussion sustained on [Date of Injury]. Based on my clinical evaluation, the student has met the following criteria for returning to school:

Clearance Status:

[] The student is cleared to return to school full-time with no academic accommodations.

[] The student is cleared to return to school with the following academic accommodations:

- Shortened school days (e.g., half days)
- Frequent rest breaks during the day
- Extended time for assignments and testing
- Reduced workload or homework
- Avoidance of loud environments (music room, cafeteria, pep rallies)
- Avoidance of bright lights or screen time

Physical Activity Restrictions:

The student is NOT yet cleared for physical education (PE), contact sports, or vigorous physical activity. A separate "Return to Play" clearance will be required following the successful completion of a supervised exertion protocol.

Follow-Up:

The student is scheduled for a follow-up evaluation on [Date]. Please contact my office at [Phone Number] if the student experiences a significant increase in symptoms during the school day.

Sincerely,

[Doctor Name/Signature]

[Medical License Number]

[Clinic/Practice Name]

[Contact Information]