Date: [Date]

To: [School Name / Sports Organization / Employer]

Subject: Medical Clearance for Return to Activity

Patient Name: [Patient First and Last Name]
Date of Birth: [Patient DOB]
Date of Injury: [Date of Concussion]

To Whom It May Concern,

The patient named above has been evaluated for a concussion. Following a clinical evaluation and a review of their progress, I am pleased to report that the patient is now asymptomatic at rest and with exertion.

The patient has successfully completed the required multi-stage Return-to-Play/Return-to-Learn protocol without any recurrence of symptoms. Therefore, I am providing medical clearance for the patient to return to full, unrestricted activity, including:

- Full academic workload without accommodations.
- Full participation in physical education classes.
- Full participation in competitive sports and contact practices.
- Full occupational duties.

If the patient experiences a return of symptoms (such as headache, dizziness, or confusion) during any activity, they must stop immediately and be re-evaluated by a medical professional.

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Medical License Number]
[Clinic/Hospital Name]
[Phone Number]