**Date:** [Date]

**To:** [Coach Name/Athletic Department]
**Organization:** [School/Club Name]

**RE: Medical Clearance for [Athlete Full Name]**
**Date of Birth:** [DOB]

To whom it may concern,

I have evaluated [Athlete Full Name] following their injury on [Date of Injury]. At this time, the athlete is cleared to return to physical activity with the following **restrictions**:

**Authorized Activities:**
[e.g., Non-contact drills, light jogging, individual skill work]

**Prohibited Activities:**
[e.g., Full contact, tackling, heavy lifting, jumping]

**Required Accommodations:**
[e.g., Use of protective brace, maximum 30 minutes of activity, frequent rest breaks]

This restricted status is effective from [Start Date] until [End Date/Follow-up Date]. The athlete will be re-evaluated on [Date] to determine if they can progress to full, unrestricted participation.

If the athlete experiences any pain, dizziness, or recurrence of symptoms during these activities, they must stop immediately and notify their medical provider.

Sincerely,

[Signature]

**[Provider Name, Title]**
[Clinic/Hospital Name]
[Phone Number]
[Email Address]