Date: [Date]

To: [Coach/Athletic Director/School Name]
From: [Physician/Healthcare Provider Name]
Subject: Graduated Return to Sport Authorization

Athlete Name: [Athlete Name]
Date of Birth: [DOB]
Injury Date: [Date of Injury]

To whom it may concern,

[Athlete Name] has been evaluated following a concussion/injury and is now cleared to begin a supervised Graduated Return to Sport (RTS) protocol. The athlete must remain asymptomatic at their current level for 24 hours before progressing to the next stage.

Step 1: Symptom-limited activity
Daily activities that do not provoke symptoms.

Step 2: Light aerobic exercise
Walking or stationary cycling at slow to medium pace. No resistance training.

Step 3: Sport-specific exercise
Running or skating drills. No head impact activities.

Step 4: Non-contact training drills
Harder training drills (e.g., passing drills). May start progressive resistance training.

Step 5: Full contact practice
Following medical clearance, participate in normal training activities.

Step 6: Return to sport
Normal game play.

If any symptoms return during activity, the athlete must stop immediately, rest for 24 hours, and return to the previous successful step. Please contact my office at [Phone Number] if you have any questions.

Sincerely,

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