Date: [Date]

To: [School Name / Sports Organization / Employer]
Attn: [Name of Official or Department]

RE: Medical Clearance for [Patient Full Name]
Date of Birth: [Patient Date of Birth]
Date of Injury: [Date of Injury]

To Whom It May Concern,

[Patient Name] has undergone a comprehensive neurological evaluation following a reported concussion/head injury. Based on the clinical examination and a review of the patient's symptoms, I have determined the following:

Current Status:
The patient is currently asymptomatic at rest and during physical/cognitive exertion. Neurological functions, including balance, coordination, and cognitive processing, have returned to baseline levels.

Clearance Recommendations:

- The patient is cleared to return to full academic/work activities without restrictions.
- The patient is cleared to begin a graduated Return-to-Play protocol.
- The patient is cleared for full participation in competitive sports and physical education, effective [Date].

Special Instructions:
[Insert any specific limitations or "None"]

Should the patient experience a recurrence of symptoms (such as headache, dizziness, or confusion), they are instructed to cease activity immediately and follow up with this office.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO/Specialty]
[Medical Facility Name]
[Phone Number]
[License Number]