Date: [Insert Date]

To: [Parent/Guardian Name, School Name, or Athletic Organization]

Patient Name: [Insert Patient Name]
Date of Birth: [Insert DOB]
Date of Injury: [Insert Date of Injury]

Subject: Medical Clearance for Return to Normal Activities

To Whom It May Concern,

The above-named patient has been evaluated for a concussion. Following a clinical assessment and a review of their recovery progress, I am confirming that the patient has successfully completed the required concussion protocol.

The patient is currently asymptomatic at rest and during physical exertion. Therefore, I am providing medical clearance for the following (check all that apply):

- Full return to academic activities/school without restrictions.
- Full return to physical education (PE) classes.
- Full return to competitive sports and contact activities.
- Discharge from active concussion management.

Ongoing Recommendations:
Despite this clearance, the patient should be monitored for any recurring symptoms. If headaches, dizziness, or cognitive difficulties return during activity, the patient must stop immediately and seek a follow-up evaluation.

If you have any questions regarding this discharge, please contact our office at [Insert Phone Number].

Sincerely,

[Physician Signature]

[Physician Name, Title]
[Medical Facility Name]
[License Number]