Physician Letter to School

To Whom It May Concern:

Patient Name: _____ DOB: _____

INJURY STATUS	***Date of Concussion Diagnosis by MD/DO:*** _____

__ Has been diagnosed by a MD/DO with a concussion and is currently under our care.
Medical follow-up evaluation is scheduled for *(date)*: _____

__ Was evaluated and did not have a concussion injury. There are no limitations on school and physical activity.

ACADEMIC ACTIVITY STATUS *(Please mark all that apply)*

__ **This student is not to return to school.**

__ This student may begin a return to school based on successful progression through the ***CIF Concussion Return to Learn Protocol.*** This student requires the necessary school accommodations set forth on the ***Physician (MD/DO) Recommended School Accommodations Following Concussion*** form.

__ This student is no longer experiencing any signs or symptoms of concussion and may be released to full academic participation.

Comments: _____

PHYSICAL ACTIVITY STATUS *(Please mark all that apply)*

__ **This student is not to participate in physical activity of any kind.**

__ This student is not to participate in recess or other physical activities except for untimed, voluntary walking.

__ This student may begin a graduated return to play progression (see ***CIF Concussion RTP Protocol*** form).

__ This student has medical clearance for unrestricted athletic participation (Has completed the ***CIF Concussion RTP Protocol***).

Comments: _____

Physician *(MD/DO)* **Signature:** _____ **Exam Date:** _____

Physician Stamp and Contact Info:

Parent/Guardian Acknowledgement Signature: _____ **Date:** _____