Physician Letter to School

To Whom It May Concern:

Patient Name: ______________________________ DOB: ______________

INJURY STATUS	*Exam Date:* ______________________
__	Has been diagnosed by a MD/DO with a concussion and is 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, PE class, or other physical activities except for untimed, voluntary walking.
__	This student may begin a monitored, graduated return to play progression (per ***CIF Concussion RTP Protocol***).
__	This student is cleared for full, unrestricted athletic participation (has completed the ***CIF Concussion RTP Protocol***).
Comments:	______________________________

Physician *(MD/DO)* Signature: ______________________________ Date: ______________

Physician Stamp and Contact Info:

Parent/Guardian Acknowledgement Signature: ______________________________ Date: ______________