

Physician Letter to School

To Whom It May Concern:

Patient Name: _____ DOB: _____

INJURY STATUS	Date of Concussion Diagnosis by MD/DO: _____
<input type="checkbox"/> Has been diagnosed by a MD/DO with a concussion and is currently under our care.	
<input type="checkbox"/> Medical follow-up evaluation is scheduled for (date): _____	
<input type="checkbox"/> 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)
<input type="checkbox"/> This student is not to return to school.
<input type="checkbox"/> 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.
<input type="checkbox"/> This student is no longer experiencing any signs or symptoms of concussion and may be released to full academic participation.
<i>Comments:</i> _____
PHYSICAL ACTIVITY STATUS (Please mark all that apply)
<input type="checkbox"/> This student is not to participate in physical activity of any kind.
<input type="checkbox"/> This student is not to participate in recess or other physical activities except for untimed, voluntary walking.
<input type="checkbox"/> This student may begin a graduated return to play progression (see CIF Concussion RTP Protocol form).
<input type="checkbox"/> This student has medical clearance for unrestricted athletic participation (Has completed the CIF Concussion RTP Protocol).
<i>Comments:</i> _____

Physician (MD/DO) Signature: _____

Exam Date: _____

Physician Stamp and Contact Info:

Parent/Guardian Acknowledgement Signature: _____

Date: _____