



Physician Letter to School



To Whom It May Concern:

Student Name: _____ DOB: _____

INJURY STATUS	<i>Date of Concussion Diagnosis by MD/DO:</i> _____
	<i>Date of Injury:</i> _____
<input type="checkbox"/> Student 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"/> Student was evaluated and did not have a concussion injury. There are no limitations on school and physical activity.	

ACADEMIC ACTIVITY STATUS <i>(Please mark all that apply)</i>	
<input type="checkbox"/>	This student is not to return to school.
<input type="checkbox"/>	This student may begin to return to school based on successful progression through the <i>CIF Concussion Return to Learn Protocol</i> . This student requires the necessary school accommodations set forth on the <i>Physician (MD/DO) Recommended School Accommodations Following Concussion</i> form.
<input type="checkbox"/>	This student is no longer experiencing any signs or symptoms of concussion and may be released to full academic participation.
<u>Comments:</u> _____	
PHYSICAL ACTIVITY STATUS <i>(Please mark all that apply)</i>	
<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 <i>CIF Concussion RTP Protocol</i> form).
<input type="checkbox"/>	This student has medical clearance for unrestricted athletic participation (Has completed the <i>CIF Concussion RTP Protocol</i>).
<u>Comments:</u> _____	

Physician (MD/DO) Signature: _____

Exam Date: _____

Physician Stamp and Contact Info:

Parent/Guardian Acknowledgement Signature: _____

Date: _____