

To V	Vhom It May Concern:	
Stuc	lent Name:	DOB:
	IN HIDV STATUS	Date of Concussion Diagnosis by MD/DO:
	INJURY STATUS	Date of Injury:
	Has been diagnosed by a MD/DO with a concussion and is currently under our care.	
_	Medical follow-up evaluation is scheduled for (date):	
_	/as 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 to return to school based on graduated 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.	
_	This student 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: