

## Davis Senior High School 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.

\_\_\_\_\_ **This student is not to return to school.**

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

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: \_\_\_\_\_

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### **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) I certify that I am trained in concussion diagnosis and management of concussions

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Physician Stamp and Contact Info:**

**Parent/Guardian Acknowledgement Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

DSHS Athletics use only

**Date Received:** \_\_\_\_\_

**Received by:** \_\_\_\_\_