[Date]

To: [School Name] Administration and Nursing Staff
From: [Physician Name/Clinic Name]
Re: Return to School Accommodations for [Student Name]
Date of Birth: [Student DOB]

Dear School Officials,

[Student Name] underwent surgery on [Date of Surgery] and has been cleared to return to school on [Return Date]. To ensure a safe recovery, the following accommodations are required until [End Date or Next Follow-up Appointment]:

- **Physical Activity:** No PE classes, sports, or strenuous recess activities.
- **Mobility:** Student may require the use of [crutches/wheelchair/elevator pass]. Allow 5 minutes for early transition between classes to avoid crowded hallways.
- **Weight Limits:** No lifting or carrying more than [Number] pounds. Student may require a second set of books for home or assistance carrying a backpack.
- **Medical Needs:** Student may require visits to the school nurse for [wound care/medication administration/pain management].
- **Rest Intervals:** Allow the student to rest in the nurse's office if they experience significant fatigue or pain.
- **Academic Adjustments:** Extra time for assignments or testing due to [fatigue/medication side effects].

Please contact our office at [Phone Number] if you have any questions regarding these medical requirements.

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Medical License Number]