Date: [Insert Date]

To: [Name of School/Organization Administration or Disability Services]

Subject: Medical Accommodation Request for Backpack Weight Restriction

Patient Name: [Insert Patient Name]
Date of Birth: [Insert Date of Birth]

To Whom It May Concern,

I am the treating physician for [Patient Name]. Due to a diagnosed medical condition, it is medically necessary for this student to observe specific physical restrictions regarding the carrying of heavy loads.

Effective immediately, please provide the following accommodations:

- **Weight Limit:** The patient should not carry a backpack or bag weighing more than [Insert Number, e.g., 5 or 10] pounds.
- **Storage:** Access to a locker or a secure location to store textbooks and heavy materials between classes to minimize carrying time.
- **Digital Materials:** Permission to use digital versions of textbooks or tablet devices to reduce the need for physical books.
- **Duplicate Books:** If possible, a second set of textbooks to be kept at home.
- **Duration:** These restrictions should remain in place until [Insert Date or "Further Notice"].

These accommodations are necessary to prevent the exacerbation of the patient's condition and to ensure their safety and physical well-being while on campus.

If you require further clinical documentation or have questions regarding these requirements, please contact my office at [Insert Phone Number].

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]
[Medical Practice/Clinic Name]
[License Number]
[Contact Email/Phone]