Date: [Date]

To: [School Name / Principal Name / School Nurse]
From: [Physician Name/Clinic Name]
Subject: Medical Accommodations for [Student Name]

To whom it may concern,

This letter is to certify that [Student Name] (DOB: [Date of Birth]) recently underwent surgery on [Date] and is currently under my care. Due to the nature of the recovery process, the student is required to use crutches for mobility and is restricted from putting weight on their [Left/Right] leg.

I am requesting the following accommodations be provided from [Start Date] until [Estimated End Date] to ensure the student's safety and continued academic participation:

- Five minutes early release from classes to navigate hallways safely between periods.
- Access to the school elevator (if applicable).
- Assistance with carrying books, lunch trays, or heavy school bags.
- Exemption from Physical Education (PE) classes and any strenuous physical activity.
- Permission to keep the injured leg elevated during classroom instruction.
- Extended time to travel between the classroom and the restroom or nurse's office.

The student will be re-evaluated on [Follow-up Date], at which time these restrictions may be updated. If you have any questions regarding these requirements, please contact my office at [Phone Number].

Sincerely,

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