Date: [Date]

To: [School Name] Administration and Disability Services

Re: Educational Accommodations for [Student Name]
Date of Birth: [Student DOB]

To Whom It May Concern,

I am the treating [Physician Title/Specialty] for [Student Name]. Due to [Student's Medical Condition/Diagnosis], the student requires the use of a pediatric mobility scooter to safely and effectively navigate the school environment.

To ensure equal access to education, the following accommodations are medically necessary:

- **Access:** The student must be allowed to use their mobility scooter in all areas of the school, including classrooms, hallways, the cafeteria, and assembly areas.
- **Storage:** A designated, secure area must be provided to park and charge the scooter if necessary.
- **Passing Time:** The student may require extra time between classes to navigate hallways safely or permission to leave class five minutes early to avoid crowded corridors.
- **Accessibility:** All school activities, including field trips and outdoor events, must be held in locations accessible by scooter.
- **Physical Assistance:** Staff should be informed on how to assist with door opening or elevator operation if the student cannot do so independently.
- **Emergency Protocol:** An individualized evacuation plan must be established for the student in the event of an emergency or power failure.

These accommodations are required to prevent physical fatigue, avoid injury, and ensure the student can participate fully in the academic curriculum. This recommendation is effective as of [Start Date] and will be re-evaluated on [Review Date].

If you have any questions regarding these medical requirements, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Medical Practice/Clinic Name]