Date: [Insert Date]

To: [School Name] Administration and Section 504/IEP Coordinator

Re: Mobility Aid Medical Necessity for [Student Name]
Date of Birth: [Student Date of Birth]

To whom it may concern,

[Student Name] is currently under my care for physical therapy due to [Diagnosis/Condition]. To ensure safety, independence, and participation in the school environment, it is medically necessary for the student to use the following mobility aid(s):

Prescribed Equipment: [e.g., Manual wheelchair, walker, crutches, gait trainer]

Duration of Use: [e.g., Permanent, or expected end date]

Required Accommodations:

- Student requires the use of the device in all areas of the school (classrooms, hallways, cafeteria).
- Student requires use of the elevator for any floor level changes.
- Student may require extra time for transitions between classes.
- Student requires accessible seating and a clear path of travel.
- [Optional: Specific instructions for storage of device when not in use].

Physical Activity Restrictions:
[e.g., No high-impact activities, modified PE, or no restrictions while using device].

Please contact me at [Phone Number] or [Email Address] if you require further clinical documentation or have questions regarding these recommendations.

Sincerely,

[Signature]

[Printed Name], PT, DPT
[Clinic/Facility Name]
[License Number]