[Date]

[Physician Name/Clinic Name]
[Address]
[City, State, Zip Code]
[Phone Number]

To: [School Name] Adaptive Physical Education Department / IEP Team

RE: Mobility Aid Recommendation for [Student Name]
Date of Birth: [DOB]

To Whom It May Concern,

This letter serves to formally document the medical necessity for [Student Name] to utilize a mobility aid during Adaptive Physical Education (APE) sessions and general school transit.

Due to [Student's Diagnosis/Physical Limitation], the student requires the use of the following equipment:

- **Mobility Device:** [e.g., Manual Wheelchair, Power Chair, Gait Trainer, Walker, Crutches]
- **Frequency of Use:** [e.g., Continuous, For distances over 50 feet, For balance support only]

Specific Participation Guidelines:

- The student should remain in the mobility aid for [all/specific] APE activities.
- [Specify if student can transfer out of aid for floor work or stretching].
- [Specify any weight-bearing restrictions].
- [Specify any necessary modifications to the device for safety, e.g., anti-tippers].

The use of this mobility aid is essential to ensure the student's safety, stability, and maximum participation in the physical education curriculum. Please incorporate these requirements into the student's Individualized Education Program (IEP) or 504 Plan.

If you require further clinical information or have questions regarding these restrictions, please contact my office.

Sincerely,

[Physician Signature]
[Physician Name, Credentials]
[Medical License Number]