

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

To [School Principal Name] and [School Nurse Name],

Re: [Student Name]  
Date of Birth: [Student DOB]

This letter is to certify that [Student Name] has been under my medical care for a serious health condition. They are cleared to return to school on [Return Date] following an extended medical absence.

Because [Student Name] is immunocompromised, please implement the following medical necessities to ensure their safety:

- **Infection Control:** The student should be allowed to wear a high-quality mask (N95/KN95) at their discretion. Frequent handwashing and access to hand sanitizer are required.
- **Notification of Illness:** Please notify the parents immediately if there is an outbreak of contagious illness in the classroom (e.g., Chickenpox, Measles, Flu, or COVID-19).
- **Physical Distancing:** When possible, the student should be seated in a well-ventilated area or away from peers showing visible symptoms of illness.
- **Activity Restrictions:** [Insert specific restrictions regarding PE or recess, or write "No restrictions at this time"].
- **Academic Support:** Due to their condition, the student may require frequent rest breaks or a modified schedule during the initial transition period.

Please contact my office at [Phone Number] if you require further clarification regarding these medical accommodations or the student's transition back to the classroom.

Sincerely,

[Physician Signature]

[Physician Printed Name]  
[Medical License Number]