

Date: [Date]

To: [Principal Name] / [School Nurse Name]
[School Name]
[School Address]

Re: Return to School for [Student Name]
Date of Birth: [Student DOB]

Dear [School Official Name],

This letter is to certify that [Student Name] has been under the care of [Hospital/Facility Name] for inpatient rehabilitation from [Start Date] to [End Date].

The student is cleared to return to school on [Return Date]. Due to the nature of their medical recovery, we recommend the following accommodations and restrictions:

Physical Restrictions:

[e.g., No physical education classes, limit stairs, or frequent rest breaks]

Academic Adjustments:

[e.g., Reduced homework load, extended time for testing, or shortened school days]

Medical Needs:

[e.g., Medication administration times or use of assistive devices]

We request a meeting to discuss a formal 504 Plan or Individualized Education Program (IEP) if necessary to support the student's transition. A member of our clinical team is available to speak with the school nurse or counselor regarding these recommendations.

If you have any questions, please contact [Contact Person Name] at [Phone Number] or [Email Address].

Sincerely,

[Doctor Name/Signature]
[Title/Department]
[Facility Name]