Date: [Date]

To: School Administration / Health Office
School Name: [School Name]

RE: [Student Name]
Date of Birth: [Date of Birth]

To Whom It May Concern,

This letter is to certify that [Student Name] was under my medical care and was hospitalized from [Admission Date] to [Discharge Date].

The student is now medically cleared to return to school on [Return Date] with the following status:

Activity Restrictions:
[ ] No restrictions; full participation in all activities (including PE and recess).
[ ] Limited physical activity until [Date]. No contact sports or heavy lifting.
[ ] Other: [Specify restrictions]

Academic Accommodations:
[ ] No accommodations needed.
[ ] Modified school day (hours: [Time Range]) until [Date].
[ ] Frequent rest breaks as needed.
[ ] Extension on assignments/tests due to medical absence.

Medications/Treatments at School:
[ ] None.
[ ] The following medication must be administered: [Medication Name/Dose/Time].
(Note: Attached is the signed medication authorization form.)

If you have any questions regarding this student's transition back to the classroom, please contact our office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]
[Practice/Hospital Name]
[Contact Information]