Date: [Date]

To: [School Name / School Nurse]

Re: [Student Name]

Date of Birth: [DOB]

To Whom It May Concern,

The above-named student was hospitalized from [Admission Date] to [Discharge Date] for [Reason for Admission/Surgery]. The student is now medically cleared to return to school on [Return Date] with the following restrictions and accommodations:

1. Physical Activity:

- [ ] No Physical Education (PE) classes until [Date].
- [ ] No recess or contact sports until [Date].
- [ ] Restricted to [Specific Activity] only.

2. Mobility Aids:

- [ ] Student requires the use of: [Crutches / Walker / Wheelchair / Knee Scooter].
- [ ] Student requires elevator access.
- [ ] Student requires 5-minute early dismissal from classes to transition between rooms safely.

3. Orthopedic Devices:

- [ ] Student must wear a [Cast / Brace / Splint] at all times.
- [ ] Weight-bearing status: [Non-weight bearing / Partial weight bearing / Full weight bearing].

4. Additional Accommodations:

- [ ] Extra set of books for home use to avoid carrying a heavy backpack.
- [ ] Use of a footstool to elevate the [Right/Left] leg while sitting.
- [ ] Assistance with carrying lunch tray or heavy items.

These restrictions shall remain in effect until [Follow-up Appointment Date]. Please contact our office at [Phone Number] if you have any questions.

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Clinic/Hospital Name]