Date: [Date]

To: [School Name] Administration / School Nurse
Student Name: [Student Full Name]
Date of Birth: [Date of Birth]

To Whom It May Concern,

This letter is to certify that the above-named student was under my care from [Start Date] to [End Date] and is now medically cleared to return to school on [Return Date].

However, due to recent hospitalization, the student is subject to the following **restricted activities** for the period of [Duration, e.g., 2 weeks] or until [Specific Date]:

- No physical education (PE) classes or contact sports.
- No recess or strenuous playground activity.
- No heavy lifting (maximum [Number] lbs).
- Frequent rest breaks as needed during the school day.
- [Insert Additional Restriction or "None"]

The student is permitted to participate in all other academic and stationary classroom activities. We will re-evaluate these restrictions on [Follow-up Appointment Date].

If you have any questions or require further clarification, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Medical Facility/Clinic Name]