**Date:** [Date]

**To:** [School Name] Administration / School Nurse
**Re:** [Student Name]
**Date of Birth:** [DOB]

To Whom It May Concern,

This letter is to certify that [Student Name] was hospitalized from [Admission Date] to [Discharge Date] under the care of the Neurology Department for [Diagnosis/Reason for Admission].

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

- **Full Participation:** The student may return to all academic and physical activities without restrictions.
- **Modified Participation:** The student may return with the specific accommodations listed below.

**Recommended Accommodations (if applicable):**

- Frequent rest breaks during the school day.
- Reduced workload or extended time for assignments/testing.
- Avoidance of bright lights or loud environments (e.g., gym, cafeteria).
- Exemption from Physical Education (PE) or contact sports until [Date].
- Specific medication administration: [List Medication/Schedule if needed].

**Emergency Contact/Follow-up:**
Please contact our office at [Phone Number] if the student displays any of the following symptoms: [List red-flag symptoms, e.g., seizure, severe headache, confusion].

The student is scheduled for a follow-up appointment on [Date].

Sincerely,

[Physician Signature]
[Physician Name, Title]
[Hospital/Clinic Name]
[Phone Number]