Date: [Insert Date]

To: [School Name]
Attn: School Nurse / Administration
[School Address]

Re: Authorization for Partial School Attendance

Student Name: [Student First and Last Name]
Date of Birth: [MM/DD/YYYY]

To Whom It May Concern,

This letter is to certify that [Student Name] is currently under my medical care. At this time, it is my clinical recommendation that the student return to school on a half-day basis only.

This modified schedule is effective from [Start Date] through [End Date/Date of Re-evaluation].

Recommended Schedule:
The student should attend school during the [Morning/Afternoon] session and should not exceed [Number] hours of instruction per day.

Reason for Restriction:
[Optional: Briefly state reason, e.g., Post-concussion recovery, Recovery from surgery, or Chronic illness management].

Physical Restrictions:
[e.g., No PE, No heavy lifting, or No restrictions].

I will re-evaluate the student's progress on [Date] to determine if they can resume a full-day schedule. Please contact my office at [Phone Number] if you have any questions.

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Medical Practice/Clinic Name]
[Stamp/License Number]