[Physician Name/Clinic Name]
[Clinic Address]
[Phone Number]
[Date]

To: [School Name/Principal Name]
[School Address]

RE: Medical Clearance for Reduced School Hours

Student Name: [Student Full Name]
Date of Birth: [DOB]

To Whom It May Concern,

I am the treating physician for [Student Name]. Due to a documented medical condition, it is my professional recommendation that this student return to school on a reduced schedule to support their health and recovery.

Recommended Schedule:
The student is cleared to attend school for [Number] hours per day, or from [Start Time] to [End Time]. This modified schedule should remain in effect from [Start Date] until [End Date/Re-evaluation Date].

Necessary Accommodations:
While at school, the student may require the following:
- [e.g., Frequent rest breaks]
- [e.g., Access to the nurse's office]
- [e.g., Limited physical exertion]

We will monitor the student's progress and provide an update regarding a return to full-time hours on [Follow-up Date]. Please contact my office at [Phone Number] if you require further clarification.

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Medical License Number]