Date: [Date]

To: [School Name / School Nurse / Administration]

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

To Whom It May Concern,

This letter is to certify that [Student Name] is cleared to return to school on [Return Date] following orthopedic surgery performed on [Surgery Date].

Medical Equipment/Assistive Devices:
The student is currently using: [e.g., Crutches, Wheelchair, Knee Scooter, Sling, Boot, Brace].

Weight-Bearing Status:
[e.g., Non-weight bearing / Partial weight bearing (50%) / Weight bearing as tolerated / Full weight bearing] on the [Left/Right] [Body Part].

Required Accommodations:

- Extra time to transition between classes.
- Early dismissal from class (5 minutes) to avoid crowded hallways.
- Elevator access if available.
- Second set of books to keep at home to avoid carrying a heavy backpack.
- Elevating the affected limb during the school day as needed.
- Assistance with carrying lunch trays or heavy materials.

Physical Education and Activities:
The student is restricted from all Physical Education (PE), recess, and sports activities until [Date/Next Follow-up Appointment].

Medication:
[Instructions regarding any medication to be administered during school hours, if applicable].

Please contact my office at [Phone Number] if you have any questions or require further clarification.

Sincerely,

[Doctor Name, MD/DO]
[Clinic/Hospital Name]
[Contact Information/Stamp]