Date: [Date]

To: [School Name / School Nurse]

Re: Return to School Clearance

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

To Whom It May Concern,

The above-named student was evaluated on [Date of Evaluation] for a [Location of Sprain, e.g., Right Ankle] sprain. The student is medically cleared to return to school on [Return Date] with the following status:

Activity Restrictions:

- [ ] No Physical Education (PE) or sports until [Date].
- [ ] Limited physical activity (e.g., walking only, no running/jumping).
- [ ] Full participation in all school activities.

Assistive Devices/Support:

- [ ] Use of crutches / walker required until [Date].
- [ ] Use of brace / splint / walking boot.
- [ ] Elevator access required.
- [ ] Extra time for transitions between classes.

Additional Instructions:
[Insert any specific medication or icing instructions here]

Please contact our office at [Phone Number] if you have any questions regarding these recommendations.

Sincerely,

[Physician Signature]
[Physician Name and Title]
[Clinic/Hospital Name]