**[Physician Name/Clinic Name]**
[Address]
[City, State, Zip Code]
[Phone Number]
[Date]

**To: [School Name / School Nurse / Administration]**

**RE: Medical Device Clearance and Accommodations**
**Student Name:** [Student Full Name]
**Date of Birth:** [DOB]

To Whom It May Concern,

I am the treating physician for [Student Name]. This letter is to provide medical clearance and specify necessary accommodations regarding the use of a medical device within the school setting.

**Medical Device:** [Name/Model of Device, e.g., Insulin Pump, CGM, Heart Monitor, Hearing Aid]
**Purpose:** [Brief reason for use]

**Required Accommodations:**

- The student must be allowed to wear and operate this device at all times during school hours, including physical education and extracurricular activities.
- The student requires access to a [Smartphone/Receiver/Handheld Monitor] to monitor data from the device.
- The student is permitted to keep the device and any necessary supplies on their person or in their immediate vicinity.
- [Additional Accommodation: e.g., Access to private area for adjustments, permission to carry water, etc.]

**Staff Support:**
[Detail if staff assistance is needed or if the student is self-sufficient in managing the device].

**Emergency Procedures:**
In the event of device failure or an alarm, the following steps should be taken: [Insert brief emergency instructions].

If you have any questions or require further documentation, please contact my office at [Phone Number].

Sincerely,

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