[Doctor's Name/Clinic Name]
[Clinic Address]
[Phone Number]
[Date]

To: [School Name/School Nurse/Physical Education Department]

RE: Medical Clearance for [Student Name]
Date of Birth: [Student DOB]

To Whom It May Concern,

This letter is to certify that [Student Name] is currently under my care for an orthopedic condition affecting the [Body Part - e.g., Right Knee]. As part of their treatment plan, the student is required to wear a medical brace (Type: [Type of Brace]) during school hours.

Brace Usage Requirements:
The student must wear the brace during the following times (check all that apply):
[ ] At all times while on campus
[ ] During Physical Education (PE) and sports
[ ] Only during transitions/walking between classes
[ ] Other: [Specify]

Activity Restrictions:
[ ] The student is cleared for full participation in PE while wearing the brace.
[ ] The student is cleared for modified physical activity (see attached limitations).
[ ] The student is excused from all physical activity until [Date].

Special Accommodations:
[ ] Extra time to travel between classes.
[ ] Elevator access (if applicable).
[ ] Assistance with heavy books/backpack.

This authorization is effective from [Start Date] until [End Date/Next Evaluation].

If you have any questions regarding these medical instructions, please contact our office.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO/DPM]
[License Number]