Date: [Insert Date]

To: [Principal Name / School Nurse / Section 504 Coordinator]
School Name: [Insert School Name]
Re: School Re-entry for [Student Name]
Date of Birth: [Insert DOB]

Dear School Administration and Staff,

[Student Name] is currently under the care of the Pediatric Orthopedic Rehabilitation team following [Insert Surgery/Injury Date]. They are cleared to return to school on [Insert Return Date] with the following medical accommodations and restrictions.

1. Mobility and Access:

- The student requires the use of [Crutches / Walker / Manual Wheelchair / Power Wheelchair].
- The student must be allowed to use the elevator (if available) and requires [Insert Number] extra minutes for transitions between classes.
- The student should be dismissed [Insert Number] minutes early from each period to avoid crowded hallways.
- The student requires a second set of textbooks to be kept at home to avoid carrying a heavy backpack.

2. Physical Activity Restrictions:

- No Physical Education (PE) classes or contact sports until [Insert Date].
- No running, jumping, or climbing on playground equipment.
- Recess should be supervised with sedentary options provided.

3. Classroom Accommodations:

- Elevated seating/footrest for the [Left/Right] leg to manage swelling.
- Frequent "stretch breaks" or position changes every [Insert Number] minutes.
- Assistance with carrying lunch trays or heavy materials.

4. Toileting and Personal Care:

- The student requires scheduled or on-demand access to the nurse's office for [Medication Administration / Dressing Changes].
- Assistance may be required for clothing adjustments or transfers in the restroom.

5. Emergency Evacuation:

- In the event of a fire drill or emergency, a designated staff member must be assigned to assist the student with evacuation.

These restrictions are expected to remain in place until [Insert Date or Follow-up Appointment]. We will provide an updated status report following the next clinic visit.

If you have any questions regarding these medical requirements, please contact our office at [Insert Phone Number].

Sincerely,

[Physician/Therapist Name]
[Title]
[Clinic/Hospital Name]