Date: [Date]

To: [School Name] Administration / School Nurse

From: [Physician Name/Clinic Name]

Re: Return to School Medical Plan

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

To Whom It May Concern,

[Student Name] experienced a seizure event on [Date]. They are cleared to return to school on [Date] with the following temporary modifications to ensure their safety and recovery:

1. Academic Adjustments:

- Reduced school hours (e.g., half-days) until [Date].
- Frequent rest breaks as needed if fatigue occurs.
- Postponement of exams or high-stakes testing for [Number] days.
- Extended deadlines for assignments.

2. Physical Activity Restrictions:

- No Physical Education (PE) or strenuous exercise until [Date].
- No swimming or climbing activities.
- Supervision required during recess.

3. Seizure Protocol:

- Please follow the attached Seizure Action Plan.
- Emergency medication [Medication Name] should be available in the health office.
- Contact parents immediately if any seizure activity, unusual confusion, or extreme lethargy is observed.

We will re-evaluate these restrictions on [Follow-up Date]. If you have questions, please contact our office at [Phone Number].

Sincerely,

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