Date: [Insert Date]

To: [School Name] Administration and Physical Education Department

From: [Physician Name/Clinic Name]

Re: Return to School and Physical Activity Accommodations for [Student Name]

Date of Birth: [Student Date of Birth]

To Whom It May Concern,

[Student Name] was recently treated for a seizure event on [Date of Event]. They are cleared to return to school on [Return Date], subject to the following physical activity accommodations and restrictions:

Physical Activity Status (Check one):

- [ ] Full participation in PE and sports with no restrictions.
- [ ] Participation with specific restrictions (listed below).
- [ ] No physical activity/PE until [Date of Re-evaluation].

Specific Restrictions and Safety Precautions:

- **Swimming:** [e.g., Must have 1-on-1 adult supervision / Not permitted]
- **Heights:** [e.g., No climbing ropes or high equipment]
- **Contact Sports:** [e.g., Restricted until further notice / Permitted with headgear]
- **Exertion:** [e.g., Allow self-paced breaks if feeling fatigued or dizzy]

Emergency Protocol:

Please refer to the student's Seizure Action Plan. In the event of a seizure during physical activity, the student should be moved to a safe flat surface and the school nurse should be notified immediately.

These accommodations shall remain in effect until [End Date] or until a follow-up evaluation is completed.

If you have any questions, please contact our office at [Phone Number].

Sincerely,

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