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

To: [School Name / Disability Services Office]

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

To Whom It May Concern,

I am the treating physician for [Student Name]. This letter is to formally document a medical condition that results in significant light sensitivity (photophobia). Due to this condition, the student requires specific environmental accommodations to participate in educational activities without physical distress or symptom exacerbation.

I recommend the following accommodations be implemented immediately:

- Permission to wear tinted lenses or sunglasses indoors.
- Permission to wear a hat or visor to shield eyes from overhead lighting.
- Seating preference away from direct window sunlight or directly underneath bright fluorescent fixtures.
- Use of anti-glare filters on computer screens or tablets.
- Reduction of screen brightness or the use of "dark mode" for digital assignments.
- Occasional "eye rest" breaks in a dimly lit area if symptoms flare.

These accommodations are medically necessary to prevent [migraines/eye strain/dizziness/other symptoms] and to ensure the student can focus on their curriculum. This exemption should remain in effect until [Date or End of School Year].

Should you require any further medical documentation or have questions regarding these requirements, please contact my office.

Sincerely,

[Physician Signature]

[Physician Printed Name]
[Medical License Number]