**Date:** [Date]

**To:** [School Name / Teacher Name]

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

To whom it may concern,

The above-named patient is currently under the care of [Doctor Name] at [Clinic Name] for a pediatric ophthalmological condition.

Due to [Medical Reason: e.g., reduced visual acuity / ongoing treatment / recovery from surgery], it is medically necessary for this student to have **temporary preferential seating** in the classroom. We request that the student be seated in the front row or as close to the primary instructional area/whiteboard as possible to minimize visual strain and ensure clear access to educational materials.

This accommodation is requested for the following duration: [Start Date] to [End Date/Next Evaluation].

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

Sincerely,

[Doctor Signature]
[Doctor Name, Title]
[Clinic Name]