**Date:** [Date]

**To:** [School Name] Administration / School Nurse

**RE:** [Student Name]
**Date of Birth:** [Date of Birth]

To whom it may concern,

This letter is to certify that [Student Name] is under my care for an ocular condition that requires the use of an eye patch. The student is cleared to return to school on [Return Date] under the following conditions:

**Patching Schedule:**
The student is required to wear the patch over the [Left / Right / Both] eye(s) during the following school hours: [Time or Duration].

**Activity Restrictions:**
[Select one or more: No restrictions / No contact sports / Limited physical education / Use of protective eyewear required during PE]

**Classroom Accommodations:**
Due to altered depth perception and peripheral vision while patching, the following are recommended:

- Preferential seating at the front of the classroom.
- Extra time for reading or written assignments if needed.
- Assistance when navigating stairs or crowded hallways.

These requirements will remain in effect until [End Date or Next Follow-up Appointment].

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

Sincerely,

[Doctor Signature]

[Doctor Name, Title]
[Clinic/Hospital Name]
[License Number]