[Doctor Name/Clinic Name]
[Address Line 1]
[City, State, Zip Code]
[Phone Number]

Date: [Date]

To: [School Name / Principal Name / School Nurse]

RE: Return to School Medical Authorization
Student Name: [Student Name]
Date of Birth: [Date of Birth]

To Whom It May Concern,

This letter serves to confirm that [Student Name] is cleared to return to school on [Return Date] following a recent surgical procedure.

Due to the nature of the recovery process, the following medical restrictions must be implemented until [End Date or "Further Notice"]:

- **Stair Restriction:** The student is strictly prohibited from using stairs. Please provide access to an elevator or transition the student's classes to the ground floor.
- **Physical Activity:** The student is excused from Physical Education (PE) and must avoid running or strenuous activities.
- **Assistance:** The student may require early dismissal from classes (5 minutes) to navigate hallways safely.

If you have any questions or require further clarification regarding these limitations, please contact our office at [Phone Number].

Sincerely,

[Doctor Signature]

[Doctor Name, Credentials]
[Medical License Number]