Date: [Date]

To: [School Name/Administrator Name]
From: [Physician Name/Clinic Name]
Subject: Medical Necessity for School Accommodations - [Student Name]

To Whom It May Concern,

This letter is to certify that [Student Name] (DOB: [Date of Birth]) underwent orthopedic surgery on [Date of Surgery] and is currently under my care during the recovery period.

Due to the nature of the procedure and the student's current physical limitations, the following medical accommodations are required effective immediately until [Estimated End Date]:

- **Stair Exemption:** The student is strictly prohibited from using stairs. Please provide access to an elevator or relocate classes to the ground floor.
- **Mobility Aids:** The student will be using [crutches/a walker/a wheelchair/a knee scooter] and requires extra time for transitions between classes.
- **Early Release:** Permission to leave class 5-10 minutes early to avoid crowded hallways.
- **Physical Education:** Total exemption from PE and all strenuous physical activities.
- **Weight-Bearing Restrictions:** The student is [Non-Weight Bearing / Partial Weight Bearing] on the [Left/Right] leg.
- **Elevated Seating:** Access to an extra chair or stool to keep the affected limb elevated during class.

Please ensure that the student is assisted with carrying heavy items, such as textbooks or a backpack, as their balance and strength are currently compromised.

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

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Clinic/Hospital Name]