Date: [Date]

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

Subject: Post-Surgery Physical Activity Restrictions and Medical Clearance

Student Name: [Student Full Name]
Date of Birth: [Date of Birth]
Date of Surgery: [Date of Procedure]

To Whom It May Concern,

This letter is to confirm that [Student Name] is under my care following a recent surgical procedure. The student is medically cleared to return to school on **[Return Date]**, subject to the following physical activity restrictions:

Physical Activity Restrictions:

- No Physical Education (PE) classes or organized sports until [Date or Next Follow-up].
- No heavy lifting (greater than [Number] pounds).
- No running, jumping, or strenuous cardiovascular exertion.
- Avoid contact sports or activities with a high risk of falling.

Accommodations Required:

- Extra time to transition between classrooms.
- Permission to use an elevator (if applicable).
- Frequent rest breaks or access to the school nurse as needed.
- [Insert any specific medication or dressing change needs here].

These restrictions shall remain in effect until **[End Date or "further notice"]**. I will evaluate the student during their follow-up appointment on [Date] and provide an updated clearance letter at that time.

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

Sincerely,

[Doctor Name, MD/DO]
[Medical Practice Name]
[Provider Signature / Stamp]