Date: [Date]

To: [School Name / Principal's Name]
From: [Doctor's Name / Clinic Name]
Subject: Medical Necessity for Stair Restriction - [Student Name]

To whom it may concern,

This letter is to certify that [Student Name], Date of Birth: [DOB], is currently under my care following a surgical procedure performed on [Date of Surgery].

Due to the nature of the surgery and the required recovery process, the student is medically restricted from using stairs for a period of [Number] weeks, effective until [End Date].

To ensure the student's safety and continued academic participation, I recommend the following accommodations:

- Full access to the school elevator.
- Allowing the student to leave class 5 minutes early to navigate hallways safely.
- Relocation of any classes currently held on upper floors if an elevator is unavailable.
- Assistance with carrying heavy books or a backpack.

The student is cleared to attend school provided these physical restrictions are maintained. We will re-evaluate these limitations during the follow-up appointment on [Date].

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

Sincerely,

[Doctor's Signature]
[Doctor's Printed Name]
[Medical License Number]