[Date]

[Principal's Name]
[School Name]
[School Address]

Re: Return to School and Mobility Accommodations for [Student Name]

To whom it may concern,

This letter is to confirm that [Student Name] is cleared to return to school on [Date] following surgery on [Date of Surgery]. To ensure a safe environment and successful recovery, the following mobility accommodations are required:

- **Assistive Devices:** The student will be using [crutches/wheelchair/walker/knee scooter] for a period of [Duration].
- **Passing Periods:** Permission to leave class [Number] minutes early to avoid crowded hallways.
- **Elevator Access:** Full access to the school elevator (if applicable).
- **Physical Education:** Exemption from PE and strenuous physical activity until [Date].
- **Classroom Seating:** Preferential seating to allow space for elevating the affected limb or storing assistive devices.
- **Assistance:** Permission for a peer or staff member to assist with carrying books or a lunch tray.

Please contact my office at [Phone Number] if you have any questions regarding these medical requirements.

Sincerely,

[Doctor's Signature]
[Doctor's Printed Name]
[Medical Practice Name]