Date: [Date]

To: [School Name/Principal]

Re: [Student Name]
Date of Birth: [DOB]

To Whom It May Concern,

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

The student is medically cleared to return to school on **[Return Date]**, subject to the following physical restrictions:

- **Stair Restriction:** The student is strictly prohibited from using stairs until [End Date or "Further Notice"]. Please allow the student access to the school elevator or provide assistance/accommodations for classes located on upper floors.
- **Physical Activity:** No PE classes, sports, or strenuous physical activity until [Date].
- **Mobility Aids:** The student will be using [Crutches/Wheelchair/Walker/Brace] while on campus.
- **Passing Periods:** Please allow the student to leave class 5 minutes early to navigate hallways safely.

These restrictions are necessary to ensure proper healing and to prevent post-operative complications. We will re-evaluate these limitations during the follow-up appointment scheduled for [Follow-up Date].

If you have any questions, please contact our office at [Phone Number].

Sincerely,

[Doctor Name, MD/DO]
[Clinic/Hospital Name]
[Signature Line]