DATE: [Date]

TO: [School Name] Administration / School Nurse
RE: [Student Name]
DOB: [Date of Birth]

To Whom It May Concern,

[Student Name] is currently under my care following a surgical procedure performed on [Date of Surgery]. To ensure a safe recovery and prevent post-operative complications, the following medical accommodations and safety restrictions are required for their return to school on [Return Date].

Physical Activity Restrictions:

- No physical education (PE) classes or organized sports until [Date].
- No running, jumping, or strenuous physical exertion.
- No lifting more than [Number] pounds.
- Avoid crowded hallways; student should be allowed to leave class 5 minutes early to transition between periods.

School Environment Accommodations:

- Elevator access if the school has multiple floors.
- Permission to use a rolling backpack to avoid strain on the surgical site.
- Frequent bathroom breaks as needed.
- Permission to keep a water bottle at the desk for hydration.

Medication and Pain Management:

- The student may require [Medication Name] to be administered by the school nurse per the attached prescription.
- If the student experiences sudden [Specific Symptom, e.g., swelling, redness, or severe pain], please contact the parent/guardian and this office immediately.

These restrictions are expected to remain in place until [Follow-up Date/End Date], at which time the student will be re-evaluated.

Should you have any questions regarding these medical requirements, please contact our clinic at [Phone Number].

Sincerely,

[Doctor Name, MD/DO]
[Clinic/Medical Facility Name]

[Phone Number]
[Signature/Stamp]