Date: [Insert Date]

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

Re: Physical Restrictions for [Student Name]

Date of Birth: [Student DOB]

To Whom It May Concern,

This letter is to confirm that [Student Name] is cleared to return to school on [Return Date] following a recent surgical procedure performed on [Surgery Date].

Due to limited mobility and safety concerns during the recovery period, the following restrictions must be observed until [End Date or "Further Notice"]:

- **Stair Restriction:** The student is strictly prohibited from using stairs. Please provide access to an elevator or relocate classrooms to the ground floor.
- **Physical Activity:** No participation in PE, sports, or strenuous recess activities.
- **Mobility Aids:** The student will be using [Crutches / A Walker / A Wheelchair] and may require assistance navigating hallways.
- **Transition Time:** Please allow the student to leave class 5 minutes early to avoid crowded hallways.

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

Sincerely,

[Doctor's Name/Signature]
[Medical Practice Name]
[License Number]