[Physician Name/Clinic Name]
[Clinic Address]
[City, State, Zip Code]
[Phone Number]

[Date]

To: [School Name/Administration Name]

RE: Medical Clearance and Activity Restrictions for [Student Name]
Date of Birth: [Student DOB]
Date of Surgery: [Surgery Date]

To Whom It May Concern,

This letter is to certify that [Student Name] is under my care following a recent surgical procedure. The student is cleared to return to school on [Return Date] with the following strictly enforced medical restrictions:

Stair Climbing Restriction:
The student is medically excused from climbing stairs. Please ensure the student has access to an elevator or that all classes are relocated to the ground floor. This restriction is in place until [End Date or "further notice"].

Additional Restrictions:
- No physical education (PE) or strenuous physical activity.
- No heavy lifting (maximum [Number] lbs).
- [Optional: Student may require extra time between classes to navigate hallways.]

We will re-evaluate these restrictions during the follow-up appointment on [Follow-up Date].

If you have any questions regarding these medical requirements, please contact my office directly.

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Medical License Number]