

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

[Date]

To: [School Name/Principal/Athletic Director]
Re: Medical Clearance for [Student Name]
Date of Birth: [DOB]

To Whom It May Concern,

I have medically evaluated [Student Name] on [Date of Evaluation] following their injury on [Date of Injury]. The student has been diagnosed with [Type of Injury/Diagnosis].

Based on today's examination, the student is cleared to return to school activities as indicated below:

Status:

- Full Clearance: May return to all academic and physical activities (PE and competitive sports) without restrictions.
- Limited Clearance: May return to academic classes but must follow the restrictions listed below.

Physical Restrictions (if applicable):

- No Physical Education (PE) classes.
- No competitive sports or contact drills.
- No heavy lifting (over [X] lbs).
- Limited weight-bearing activities.

Special Accommodations:

- Use of crutches/boot/brace while on campus.
- Extra time for passing between classes.
- Elevator access.
- Modified schedule or frequent breaks.

These restrictions shall remain in effect until [End Date] or until the student is re-evaluated on [Follow-up Date].

If you have any questions regarding these recommendations, please contact my office.

Sincerely,

[Physician Signature]

[Physician Printed Name]

[Medical License Number]