[Doctor's Name/Medical Practice Name]
[Clinic Address]
[City, State, Zip Code]
[Phone Number]

[Date]

To: [School Name/Administrator Name]
Re: [Student's Full Name]
Date of Birth: [Student's Date of Birth]

To Whom It May Concern,

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

As of [Date of Return], the student is medically cleared to return to school with the following status (check one):

[ ] Full clearance with no restrictions.
[ ] Cleared to return with the specific restrictions listed below.

Physical Activity Restrictions:
[e.g., No PE class, no recess, no heavy lifting, or limited weight-bearing]

Duration of Restrictions:
These restrictions should remain in place until [Date or Next Follow-up Appointment].

Special Accommodations:
[e.g., Extra time between classes, use of elevator, assistance with books, or medication administration needs]

Please contact my office at [Phone Number] if you require any further information or clarification regarding this student's recovery plan.

Sincerely,

[Doctor's Signature]

[Doctor's Printed Name]
[Medical License Number]