Date: [Date]

To: [Summer Camp Name] Medical Staff/Director
From: [Doctor's Name], [Title/Credentials]
Re: Medical Clearance for [Patient Name]

Patient Name: [Patient Name]
Date of Birth: [DOB]
Date of Injury/Surgery: [Date]

To Whom It May Concern,

I am the treating orthopedic physician for [Patient Name]. This letter serves to confirm that the patient has been evaluated and is cleared to participate in summer camp activities following their recovery from [Type of Injury/Procedure].

Clearance Status (Check one):

[ ] Full Clearance: The patient may participate in all camp activities, including contact sports and swimming, without restriction.
[ ] Limited Clearance: The patient may participate with the following restrictions: [List restrictions, e.g., no heavy lifting, no running].

Required Accommodations/Equipment:

[List any necessary braces, splints, or physical therapy exercises to be continued at camp, or write "None"].

The patient is scheduled for a follow-up appointment on [Date]. Please contact my office at [Phone Number] if you have any questions regarding the patient's recovery status.

Sincerely,

[Doctor's Signature]
[Doctor's Printed Name]
[Clinic/Hospital Name]