

Date: [Date]

To: Physical Education Department / School Administration

School Name: [School Name]

Re: [Student Name]

Date of Birth: [Student DOB]

To Whom It May Concern,

[Student Name] is currently under the pediatric care of this clinic. Due to a medical condition, the student requires the following accommodations regarding Physical Education (PE) activities.

Duration of Accommodation:

From [Start Date] to [End Date/Review Date].

Type of Restriction (Check one):

- ☐ No physical activity/PE participation allowed.
- ☐ Limited participation (specific restrictions listed below).
- ☐ Return to activity via gradual progression.

Specific Restrictions & Instructions:

- ☐ No contact sports.
- ☐ No running or high-impact activities.
- ☐ Avoid overexertion / Allow frequent rest breaks.
- ☐ No lifting objects over [Number] pounds.
- ☐ Use of supportive device required (e.g., brace, splint).
- ☐ Other: [Specify details here]

Permitted Activities:

[List activities the student CAN participate in, e.g., walking, stretching, or upper body only]

Please contact our office at [Phone Number] if you have any questions or require further clarification regarding these medical limitations.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[Clinic Name]

[Clinic Address]