

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

[Date]

To: [School Name/Physical Education Department]

RE: Medical Exemption for [Student Name]

Date of Birth: [Student DOB]

To whom it may concern,

This letter is to certify that [Student Name] is currently under my care for the treatment of [Asthma/Respiratory Condition]. Due to the nature of this condition, it is medically necessary to modify or exempt the student from certain physical activities to prevent respiratory distress.

Effective Dates: [Start Date] to [End Date]

Exemption Level (Select one):

- Full exemption from all physical education activities.
- Partial exemption: Student may participate in light activity but must be allowed to stop immediately if symptoms occur.
- Environmental exemption: Student should not participate in outdoor activities during high pollen days or extreme cold temperatures.

Required Accommodations:

- Student must have immediate access to their rescue inhaler ([Medication Name]) at all times.
- Student requires a 10-15 minute warm-up period before vigorous activity.
- Please allow the student to self-monitor and rest as needed without penalty.

In the event of severe shortness of breath, wheezing, or chest tightness that does not resolve with medication, please follow the student's Asthma Action Plan and contact emergency services if necessary.

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

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]
[License Number]