

Date: [Date]

To: [School Name / Physical Education Department]

From: [Physician Name/Medical Practice]

Subject: Physician Authorized Physical Education Waiver

Student Name: [Student Full Name]

Date of Birth: [Student Date of Birth]

To Whom It May Concern,

This letter serves as formal medical authorization to excuse the above-named student from participation in Physical Education (PE) activities due to the following medical reason(s):

[Describe diagnosis or nature of restriction briefly]

Waiver Details:

- **Duration:** This waiver is effective from [Start Date] until [End Date/Full Recovery].
- **Type of Waiver:** [Full Exemption / Partial Participation]
- **Specific Restrictions:** [e.g., No contact sports, no running, no heavy lifting, etc.]
- **Permitted Activities:** [e.g., Walking, stretching, or none]

Please provide the student with an alternative academic assignment or a study hall period in place of physical activity to ensure they receive credit for the curriculum.

If you have any questions regarding these restrictions, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Printed Name]

[Medical License Number]

[Clinic/Hospital Stamp]