

**Date:** [Insert Date]

**Patient Name:** [Insert Child's Name]

**Date of Birth:** [Insert DOB]

**Guardian Name:** [Insert Parent/Guardian Name]

**Medical Record Number:** [Insert MRN]

To Whom It May Concern,

This letter serves to confirm that [Patient Name] has successfully completed treatment for [Insert Diagnosis, e.g., Distal Radius Fracture / Clubfoot Deformity].

Based on our final clinical evaluation and radiographic findings on [Insert Date of Last X-ray/Exam], the healing process is now complete. The bone/joint has achieved full clinical union, and functional alignment is satisfactory for the patient's age and activity level.

**Clinical Status:**

- Bone healing is complete.
- Range of motion is within normal limits.
- Weight-bearing status: Full / Unrestricted.

**Activity Clearance:**

The patient is cleared to return to all age-appropriate activities, including physical education, competitive sports, and playground activities, without restrictions as of [Insert Date].

**Follow-up:**

No further routine orthopedic appointments are scheduled at this time. Should the patient experience new pain, swelling, or gait changes, please contact our office for a re-evaluation.

It has been a pleasure participating in [Patient Name]'s care.

Sincerely,

[Doctor's Signature]

[Doctor's Printed Name]

[Pediatric Orthopedic Department Name]

[Facility Name]

[Phone Number]