

Date: [Date]

To: [School Name] Administration / School Nurse

RE: Return to School Clearance

Student Name: [Student Full Name]

Date of Birth: [Date of Birth]

To Whom It May Concern,

The above-named student was evaluated by our office on [Date of Evaluation] for symptoms related to a viral illness.

Based on my clinical assessment, the student is now cleared to return to school and resume all regular activities effective [**Return Date**].

The student has met the following criteria for return:

- Fever-free for at least 24 hours without the use of fever-reducing medication.
- Significant improvement in respiratory or gastrointestinal symptoms.
- Sufficient energy levels to participate in the school day.

If you have any further questions, please contact our office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Name, MD/DO/NP/PA]

[Clinic/Practice Name]

[Clinic Address]