

**Date:** [Insert Date]

**To:** [School Name / Administrator Name]

**Subject:** Medical Clearance for Return to School

**Student Name:** [Student Full Name]

**Date of Birth:** [Student Date of Birth]

To Whom It May Concern,

This letter is to certify that the student named above has been under my medical care for a confirmed or suspected case of COVID-19. As of [Date of Evaluation], I have evaluated the student and determined the following:

- The student has completed the required isolation period of [Number] days.
- The student has been fever-free for at least 24 hours without the use of fever-reducing medication.
- The student's respiratory symptoms have significantly improved.

Based on current health guidelines, [Student Name] is medically cleared to return to school and resume all normal activities, including physical education and extracurriculars, effective [**Return Date**].

**Special Instructions/Precautions:**

[Insert instructions, such as masking requirements or "None"]

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

Sincerely,

[Physician Signature]

[Physician Name, MD/DO/NP]

[Medical Practice/Clinic Name]

[Clinic Address]