

Date: [Insert Date]

To: [School Name / School Administration]

Re: Return to School Authorization

Student Name: [Insert Student Full Name]

Date of Birth: [Insert Date of Birth]

To Whom It May Concern,

This letter is to certify that the above-named student was under my medical care for Influenza (Type A/B) starting on [Insert Date].

The student has been clinically evaluated and has met the following criteria for returning to school:

- The student has been fever-free for at least 24 hours without the use of fever-reducing medications.
- Symptoms have significantly improved.
- The student is no longer considered contagious and is cleared to resume all school activities, including physical education.

Return Date: The student is authorized to return to school on [Insert Return Date].

If you have any questions or require further information, please contact my office at [Insert Phone Number].

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[Clinic/Practice Name]

[Clinic Address]