

**Date:** [Insert Date]

**To:** School Administration / School Nurse

**School Name:** [Insert School Name]

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

**Student Name:** [Insert Student Name]

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

To Whom It May Concern,

The above-named student was evaluated at my office on [Insert Date of Exam] for symptoms consistent with viral conjunctivitis (pink eye).

The student has been advised on necessary hygiene practices to prevent further transmission. Based on the current clinical presentation and the duration of symptoms, this student is no longer considered contagious and is medically cleared to return to school and all school-related activities 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/Facility Name]

[Clinic Address]

[Clinic Phone Number]