

Date: [Date]

To: School Administration / Health Office

Re: [Student Name]

Date of Birth: [Date of Birth]

To Whom It May Concern,

[Student Name] was seen at [Clinic Name] on [Date of Visit] for symptoms related to a viral fever.

The student has been evaluated and is now cleared to return to school and all school-related activities on **[Return Date]**.

This clearance is based on the following criteria:

- The student has been fever-free for at least 24 hours without the use of fever-reducing medication.
- Symptoms have significantly improved.

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

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[Clinic Name]

[Clinic Address]