

Date: [Date]

To: [School Name/Principal Name]

Re: Return to School Clearance

Student Name: [Student Name]

Date of Birth: [Date of Birth]

To Whom It May Concern,

This letter is to certify that [Student Name] was seen in my office on [Date of Visit] and was diagnosed with a Strep Throat infection.

The student began a course of antibiotic treatment on [Start Date] at [Start Time].

Per medical guidelines, the student is cleared to return to school and all school-related activities on [Return Date], provided they meet the following criteria:

- They have completed at least 24 hours of antibiotic therapy.
- They have been fever-free for at least 24 hours without the use of fever-reducing medication.
- Their symptoms have significantly improved.

Please feel free to contact my office at [Phone Number] if you have any questions or require further information.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[Clinic/Practice Name]

[Clinic Address]