

**Date:** [Insert Date]

**To:** [Insert School Name/Administration]

**Re:** COVID-19 Viral Clearance and Return to School

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

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

To Whom It May Concern,

This letter is to certify that [Student Name] has been evaluated and is now cleared to return to school and school-related activities effective [Date of Return].

The student has met the following criteria for clearance:

- At least [Number] days have passed since symptoms first appeared or since the date of the positive test.
- The student has been fever-free for at least 24 hours without the use of fever-reducing medication.
- Other symptoms (e.g., cough, shortness of breath) have significantly improved.
- The student has completed the required isolation period in accordance with current public health guidelines.

In my professional medical opinion, the student no longer poses a risk of transmitting COVID-19 to others in the school environment.

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

Sincerely,

[Signature of Healthcare Provider]

[Printed Name of Healthcare Provider]

[Title/Medical Credentials]

[Clinic/Facility Name]