[Physician Name/Clinic Name]
[Address]
[City, State, Zip Code]
[Phone Number]

[Date]

[School Principal Name]
[School Name]
[School Address]
[City, State, Zip Code]

RE: Return to School for [Student Full Name]
Date of Birth: [Student Date of Birth]

To Whom It May Concern,

Please be advised that [Student Full Name] has been under my medical care from [Start Date of Absence] to [End Date of Absence].

I have evaluated the student and determined that they are medically cleared to return to school full-time, effective [Return Date].

The student may resume all academic activities and participate in physical education (PE), sports, and extracurricular activities without any restrictions or limitations. No special accommodations are required at this time.

If you have any questions regarding this clearance, please feel free to contact my office.

Sincerely,

[Physician Signature]

[Physician Printed Name]
[Medical License Number]