Date: [Date]

To: [School Name / School Nurse / Administration]

Subject: Medical Clearance for Return to School

Student Name: [Student Full Name]
Date of Birth: [Date of Birth]

To Whom It May Concern,

The above-named student was hospitalized from [Admission Date] to [Discharge Date] due to [Diagnosis/Infectious Disease].

I am writing to certify that [Student Name] has been medically evaluated and is now cleared to return to school on [Return Date].

The student has met the following criteria for return:

- They have been afebrile (fever-free) for at least [Number] hours without the use of fever-reducing medication.
- Symptoms have improved significantly.
- They are no longer considered contagious to other students or staff.

Required Accommodations/Restrictions:
[e.g., No physical education for 1 week, restricted schedule, medication administration required, or "None"]

If you have any questions or require further documentation regarding this student's health status, please contact our office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]
[Clinic/Hospital Name]
[Phone Number]