Date: [Date]

To: [School Name] Administration / School Nurse
From: [Doctor's Name/Medical Facility]
Subject: Medical Clearance for Return to School

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

To Whom It May Concern,

This letter is to certify that [Student Name] was recently hospitalized for an asthma exacerbation from [Admission Date] to [Discharge Date]. The student has been medically evaluated and is now stable enough to return to school on [Return Date].

Please note the following requirements for the student's return:

- **Activity Restrictions:** [e.g., No physical education for 1 week / Full participation allowed / Limit outdoor play if air quality is poor].
- **Medication:** The student must have access to their rescue inhaler ([Inhaler Name]) at all times. Please follow the attached Asthma Action Plan.
- **Support:** The student may require frequent water breaks and should be monitored for signs of shortness of breath or persistent coughing.

If the student experiences significant respiratory distress, please follow emergency protocols and contact the parent/guardian immediately.

Attached is the updated Asthma Action Plan and Medication Authorization Form.

Sincerely,

[Doctor's Signature]
[Doctor's Printed Name]
[Clinic/Hospital Name]
[Phone Number]