Date: [Date]

To: [School Name] / School Nurse / Administration
From: [Provider Name/Medical Facility]
Re: [Student Name]
Date of Birth: [Student DOB]

To Whom It May Concern,

This letter is to certify that [Student Name] was under my medical care from [Start Date] to [End Date].

The student is now medically cleared to return to school on [Return Date] with no restrictions.

This clearance includes full participation in the following:

- Regular classroom instruction and full academic workload.
- Physical Education (PE) classes and sports activities.
- Recess and outdoor play.
- Extra-curricular activities and clubs.

There are no required modifications to the student's schedule, and no special accommodations are needed at this time.

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

Sincerely,

[Physician Signature]

[Physician Printed Name]
[Medical License Number]
[Facility Address]