Date: [Insert Date]

To: [School Name] Administration and School Nurse

Student Name: [Student Full Name]

Date of Birth: [Date of Birth]

To Whom It May Concern,

This letter is to certify that the student named above is under my care for the management of a chronic medical condition: [Name of Condition].

Medication Administration:
The student requires the following medication(s) to be administered during school hours:

- **Medication Name:** [Insert Name]
- **Dosage:** [Insert Dosage]
- **Time/Frequency:** [Insert Time or Intervals]
- **Route:** [e.g., Oral, Inhaler, Injection]
- **Special Instructions:** [e.g., Take with food, monitor after dose]

Emergency Procedures:
In the event of [Describe Symptoms/Emergency Scenario], please follow these steps:
[Insert Emergency Action Steps]

School Return:
The student is cleared to return to school as of [Insert Date]. They may participate in all school activities with the following restrictions:
[List Restrictions or write "None"]

Please contact my office at [Phone Number] if you require further clarification regarding this treatment plan.

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Medical Practice/Clinic Name]
[License Number]