

Date: [Date]

To: [School Name / Administrator Name]

Re: Return to School Clearance

Student Name: [Student Full Name]

Date of Birth: [Date of Birth]

To whom it may concern,

[Student Name] has been under the care of [Clinic Name/Provider Name] following a mental health-related absence. I have evaluated the student on [Date of Evaluation].

Based on this clinical assessment, it is my professional opinion that the student is medically cleared to return to school effective [Return Date].

The student is cleared for:

- Full academic participation
- Extracurricular activities and sports
- General school attendance

Recommended Accommodations (if applicable):

[Insert specific needs, e.g., shortened school days, access to counselor, or "None at this time"]

A safety plan has been discussed with the student and their legal guardian. Please contact our office at [Phone Number] if you have any questions or require further documentation regarding this transition.

Sincerely,

[Provider Signature]

[Provider Name and Title]

[Clinic/Facility Name]

[License Number]

[Phone Number]