Date: [Insert Date]

To: [Insert School Name/School Nurse]

Subject: Medical Clearance for Return to School

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

To Whom It May Concern,

This letter is to certify that the above-named student was seen in my office on [Insert Date] for evaluation of a gastrointestinal illness.

The student has been clinically evaluated and is now cleared to return to school and resume all normal activities, including physical education and sports, effective [Insert Return Date].

I confirm that the student meets the following criteria for return:

- Has been free of fever without the use of fever-reducing medication for at least 24 hours.
- Has been free of vomiting and/or diarrhea for at least 24 hours.
- Is able to tolerate a regular diet.

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

Sincerely,

[Physician Signature]

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