

Date: [Date]

To: [School Name / School Nurse]

Subject: Medical Clearance for Return to School

To Whom It May Concern,

Patient Name: [Student Name]

Date of Birth: [Student DOB]

The above-named student was under my care for a diagnosis of gastroenteritis starting on [Date].

The student is now clinically stable and has met the following criteria for return:

- No fever for at least 24 hours without the use of fever-reducing medication.
- No episodes of vomiting or diarrhea for at least 24 hours.
- Improved energy levels and ability to tolerate oral fluids/food.

[Student Name] is medically cleared to return to school and participate in all regular activities, including physical education, effective [Return Date].

Special Instructions/Accommodations (if any): [e.g., Frequent bathroom access, increased hydration]

[N/A or specify]

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

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[Clinic/Practice Name]

[Clinic Address]