

Date: [Date]

To: [Campus Health Services / School Administration]

Re: Return to Campus Medical Clearance

Student/Employee Name: [Full Name]

Date of Birth: [Date of Birth]

ID Number: [ID Number, if applicable]

To Whom It May Concern,

This letter is to certify that the individual named above was under my medical care for gastrointestinal symptoms starting on [Start Date].

The patient has been evaluated and is now cleared to return to campus activities effective [Return Date].

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

- At least 24 to 48 hours have passed since the last episode of vomiting or diarrhea without the use of medication.
- The patient has been fever-free for at least 24 hours without the use of fever-reducing medications.
- The patient is clinically stable and able to participate in normal daily activities.

Please contact my office at [Phone Number] if you require further information.

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[Clinic/Practice Name]

[Address]

[Phone Number]