

Date: [Date]

To: [School Name / Principal Name]

Re: [Student's Full Name]

Date of Birth: [Student's Date of Birth]

To Whom It May Concern,

[Student's Name] has been under my care for a digestive illness. They have been evaluated and are now cleared to return to school on [Date of Return].

The student has met the following criteria for return:

- Fever-free for at least 24 hours without the use of fever-reducing medication.
- No vomiting or diarrhea for at least 24 hours.
- Capable of participating in normal school activities.

Special Instructions or Restrictions: [None / List restrictions such as dietary needs or PE limitations]

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

Sincerely,

[Healthcare Provider Signature]

[Healthcare Provider Name and Title]

[Clinic/Facility Name]