Clinic Name: [Insert Clinic Name]

Phone: [Insert Phone Number]

Date: [Insert Date]

To the School Administration of [Insert School Name],

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

The student named above was seen at our clinic on [Date of Visit] for a gastrointestinal illness.

The student is now cleared to return to school and resume all normal activities on [Insert Return Date].

According to our clinical assessment, the student has met the following criteria for reentry:

- No fever for at least 24 hours without the use of fever-reducing medication.
- No vomiting or diarrhea for at least 24 hours.
- Ability to tolerate a regular diet and maintain hydration.

Please provide the student with any necessary accommodations regarding bathroom access or frequent hydration for the first 24 hours back at school.

If you have any questions, please contact our office.

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Clinic Stamp/License Number]