Date: [Insert Date]

To: [Name of School/Administrator]

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

To Whom It May Concern,

This letter is to certify that the student named above was seen in our office on [Date of Visit] and was diagnosed with Strep Throat.

The student has been prescribed appropriate antibiotic treatment. According to medical guidelines, they are cleared to return to school and participate in all activities on [Insert Return Date], provided that:

- They have completed at least 24 hours of antibiotic therapy.
- They have been fever-free for at least 24 hours without the use of fever-reducing medication.

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

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Clinic/Practice Name]