Date: [Date]

To Whom It May Concern:

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

This letter is to certify that the above-named patient was evaluated at our clinic on [Date of Evaluation] and has been diagnosed with Strep Throat (Streptococcal Pharyngitis).

Treatment Plan:
The patient has been prescribed a course of antibiotics. To prevent the spread of infection, it is required that the patient remains home until they have completed at least 24 hours of antibiotic treatment and are fever-free without the use of fever-reducing medications.

Activity Restrictions:
The patient is excused from [School/Work/Physical Activities] starting from [Start Date] through [End Date]. They may return to full activity on [Return Date], provided their symptoms have improved.

Special Instructions:
[Insert any additional instructions, e.g., no gym for 3 days, plenty of fluids, etc.]

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

Sincerely,

[Physician Signature]

[Physician Name, MD/DO/NP/PA]
[Clinic/Facility Name]
[Clinic Address]