Date: [Date]

To: [School Name] Health Office

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

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 started antibiotic treatment as of [Start Date/Time].

The student may return to school and resume all activities on [Return Date], provided they meet the following criteria:

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

Please contact our office at [Phone Number] if you have any questions.

Sincerely,

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