Date: [Date]

To: [School Name/School Nurse]

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

To Whom It May Concern,

The above-named student was evaluated on [Date of Examination] for symptoms of conjunctivitis (pink eye).

The student has received appropriate medical evaluation and has completed at least 24 hours of antibiotic treatment (if prescribed). At this time, the student is no longer considered contagious and is clinically cleared to return to school and all school-related activities on [Return Date].

Provider Instructions/Comments:
[Insert additional notes or "None"]

Sincerely,

Provider Signature: _____

Provider Name: [Name of Physician/Healthcare Provider]
Clinic Name: [Clinic/Hospital Name]
Phone Number: [Phone Number]