Date: [Date]

To: [Recipient Name/Organization]

Subject: Medical Clearance for [Patient Name]

To Whom It May Concern,

This letter serves to certify that [Patient Name], Date of Birth [DOB], has been under my care following a severe allergic reaction (anaphylaxis) that occurred on [Date of Incident].

The patient has completed the necessary treatment and recovery period. After a follow-up evaluation conducted on [Current Date], I find the patient to be clinically stable and fit to resume their normal activities, including [School/Work/Sports], effective [Return Date].

The following management plan is in place:

- The patient has been prescribed an Epinephrine Auto-Injector (EpiPen).
- The patient has been instructed on allergen avoidance.
- [Optional: Specific restrictions or accommodations].

If you require any further information, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Medical License Number]
[Clinic/Hospital Name]