PHYSICIAN AUTHORIZATION FOR SCHOOL RETURN

Date: [Date]

To: [School Name/School Nurse]

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

To Whom It May Concern,

The above-named student was treated for an allergic reaction that occurred on [Date of Incident].

I have evaluated the student and determined that they are medically stable and cleared to return to school and all school-related activities on [Return Date].

Emergency Care Plan:

- The student's Allergy Action Plan has been reviewed and remains [Unchanged / Updated].
- The student is cleared to resume normal activity with the following restrictions: [None / List Restrictions].
- Current medications to be kept at school: [List Medications, e.g., Epinephrine Auto-Injector, Albuterol].

If you have any questions regarding this student's care or their return to school, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]
[Clinic/Practice Name]
[Phone Number]