[Clinic Name]
[Clinic Address]
[Phone Number]
[Date]

To: [School Name / Principal Name]
[School Address]

Subject: Medical Clearance for Return to School

To Whom It May Concern,

This letter is to certify that **[Student Name]** (DOB: [Date of Birth]) has been under my care for the treatment of an **allergic reaction**.

The student has recovered sufficiently and is medically cleared to return to school and all regular school activities effective **[Date of Return]**.

Ongoing Management and Precautions:

- The student should continue to avoid exposure to the following allergens: [List Allergens].
- In the event of accidental exposure, please follow the attached Emergency Action Plan.
- The student is required to have the following medication available at school: [Medication Name, e.g., EpiPen/Antihistamine].

If you have any questions or require further clarification regarding this student's medical status, please contact our office at [Phone Number].

Sincerely,

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