[Date]

To: [School Name] Administration / School Nurse
From: [Physician Name, MD/DO]
Subject: Medical Certification for Safe School Return

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

To Whom It May Concern,

This letter serves to certify that [Student Name] is under my care for the management of the following allergic condition(s):

- [List Allergies, e.g., Peanuts, Tree Nuts, Bee Stings]

I have reviewed the student's medical history and current health status. It is my professional opinion that [Student Name] is medically cleared to return to school for in-person instruction effective [Date].

Required Accommodations & Safety Protocols:

- [Student Name] has been prescribed an Epinephrine Auto-Injector (EpiPen). This medication must be accessible at all times.
- The attached Allergy Action Plan must be followed in the event of accidental exposure.
- [List specific classroom requirements, e.g., "Nut-free table during lunch" or "Handwashing after meals"].

If the student exhibits symptoms such as [list symptoms, e.g., hives, swelling, or difficulty breathing], school staff should follow the emergency protocol immediately.

Please contact my office at [Phone Number] if you require further clarification regarding this student's medical needs.

Sincerely,

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