Date: [Insert Date]

To: [School Name / Workplace Name / Organization Name]

Re: Medical Clearance and Reentry for [Patient Full Name]

Date of Birth: [Patient Date of Birth]

To Whom It May Concern,

I am the treating physician for [Patient Name], who recently experienced a severe allergic reaction (anaphylaxis) on [Date of Incident]. [Patient Name] has been under medical supervision and is now stable and cleared to return to [School/Work/Activities] on [Return Date].

Recovery Status:
The patient has completed the acute phase of treatment. Please be advised that during the initial days of reentry, the patient may experience residual fatigue or side effects from emergency medications (such as antihistamines or corticosteroids).

Required Accommodations & Safety Protocols:

- **Emergency Medication:** [Patient Name] must have immediate access to their Epinephrine Auto-Injector ([Brand Name/Dosage]) at all times.
- **Allergy Action Plan:** Please refer to the attached Allergy Action Plan for specific emergency protocols.
- **Avoidance:** Strict avoidance of [Specific Allergen(s)] is mandatory to prevent a recurrence.
- **Activity Restrictions:** [No restrictions / Limited physical activity until Date].

If any symptoms such as hives, swelling, difficulty breathing, or dizziness occur, please follow the emergency protocol and administer epinephrine immediately.

Should you have any questions regarding this medical clearance, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

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