Date: [Date]

To: [School Name / School Nurse]

Subject: Medical Clearance for Student Return to School

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

To Whom It May Concern,

The above-named student was seen at our Urgent Care facility on [Date of Visit] for evaluation of a fever and related symptoms.

At this time, the student has been clinically evaluated and is cleared to return to school on **[Return Date]**, provided they meet the following criteria:

- They have been fever-free for at least 24 hours without the use of fever-reducing medications (such as Tylenol or Motrin).
- Symptoms have significantly improved.

Special Instructions/Limitations: [None or specify, e.g., No PE for 2 days]

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

Sincerely,

[Provider Name/Signature]
[Clinic Name]
[Clinic Stamp/Address]