Date: [Date]

To: [School Name / School Nurse]

Subject: Medical Clearance for Return to School

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

To Whom It May Concern,

This letter is to certify that [Student Name] was under my medical care for a febrile illness beginning on [Start Date].

The student has been evaluated and is now medically cleared to return to school and participate in all school activities effective **[Return Date]**.

I confirm that the student meets the following criteria for return:

- The student has been fever-free for at least 24 hours without the use of fever-reducing medications.
- Symptoms have significantly improved.
- The student is no longer considered contagious.

If you have any questions or require further information, please contact my office at [Phone Number].

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]
[Clinic/Practice Name]
[Clinic Address]