**DATE:** [Date]

**TO:** [School Name / To Whom It May Concern]

**RE:** Medical Clearance for [Student Name]

**STUDENT DATE OF BIRTH:** [DOB]

This letter is to certify that [Student Name] was seen at our clinic on [Date of Visit] for evaluation of a febrile illness.

The student has been clinically evaluated and is now cleared to return to school and all school-related activities effective [Return Date].

In accordance with standard health protocols, 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.
- [Optional: The student is no longer considered contagious.]

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

Sincerely,

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