[Clinic Name]
[Clinic Address]
[Phone Number]
[Date]

To: [School/Daycare Name]

RE: Verification of Head Lice Treatment and Return to School

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

To Whom It May Concern,

This letter is to certify that the above-named patient was examined at our clinic on [Date of Exam] for the presence of head lice.

The patient has undergone the recommended medical treatment and/or manual removal of lice and nits. Upon re-examination today, it has been determined that:

- The patient is free of live lice.
- Appropriate treatment steps have been completed according to clinical guidelines.

In accordance with our clinical findings, [Patient Name] is cleared to return to school/daycare effective: **[Return Date]**.

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

Sincerely,

[Provider Signature]
[Provider Name, Title]
[Clinic Stamp]