[Practice Name]
[Practice Address]
[City, State, Zip Code]
[Phone Number]

Date: [Current Date]

To the School Administration of: [Name of School]

RE: [Patient Name]
DOB: [Patient Date of Birth]

To Whom It May Concern,

This letter is to certify that [Patient Name] has been evaluated and treated for head lice (Pediculosis capitis).

The patient has undergone the recommended medical treatment. Following a physical examination, it has been determined that there are no live lice present. Based on current medical guidelines, the patient is no longer considered contagious and is cleared to return to school and all regular activities effective [Date of Return].

If you have any questions or require further information, please contact our office.

Sincerely,

[Signature of Healthcare Provider]
[Printed Name of Healthcare Provider]
[Title/Credentials]