Date: [Date]

To: School Administration / School Nurse
School Name: [Name of School]
Re: [Student Name]
Date of Birth: [Student Date of Birth]

To Whom It May Concern,

[Student Name] is a patient under my care at [Clinic Name]. The student experienced a seizure event on [Date of Event].

The student has been medically cleared to return to school on [Return Date].

Activity Restrictions:
[ ] No restrictions. Student may participate in all activities, including PE and recess.
[ ] The following restrictions apply: [List restrictions, e.g., no swimming, no climbing heights] until [Date].

Seizure Action Plan:
[ ] A current Seizure Action Plan is attached to this letter.
[ ] Emergency rescue medication has been prescribed: [Name of Medication/Dosage].

Please ensure that school staff are aware of the student's condition and follow the provided Seizure Action Plan should another event occur during school hours.

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

Sincerely,

[Physician Signature]
[Physician Name, MD/DO/NP]
[Clinic Name]
[Clinic Address]