

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

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

To whom it may concern,

[Student Name] is currently under the care of [Physician Name] at [Clinic Name] for the management of a seizure disorder. The student was recently seen following a seizure event that occurred on [Date].

The student is medically cleared to return to school on: **[Return Date]**.

**Activity Restrictions:**

- No restrictions.
- No swimming or climbing heights without direct supervision.
- No contact sports until cleared by neurology.
- Other: [Specify restrictions]

**School Support and Accommodations:**

- Allow for extra time on assignments/tests following a seizure due to post-ictal confusion.
- Allow for rest periods in the nurse's office if needed.
- Follow the attached Seizure Action Plan.

**Emergency Medications:**

- No rescue medication prescribed at this time.
- [Medication Name] [Dosage] [Administration Instructions] to be administered if a seizure lasts longer than [Number] minutes.

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

Sincerely,

[Physician Signature]  
[Physician Printed Name]  
[Credentials]