

Date: [Date]

To: School Administration / School Nurse

School Name: [School Name]

Re: [Patient Name]

Date of Birth: [Patient Date of Birth]

To Whom It May Concern,

The above-named patient is currently under the care of [Clinic Name/Physician Name] for the management of a seizure disorder. The patient experienced a seizure event on [Date of Event].

The patient has been evaluated and is medically cleared to return to school on [Return Date].

Activity Restrictions:

No restrictions.

No swimming or climbing heights until further notice.

Other: [Specify restrictions if any]

Seizure Action Plan:

An updated Seizure Action Plan is attached / already on file. Please ensure that all staff members responsible for the student are familiar with the emergency protocols, including the administration of rescue medication if prescribed.

Follow-Up:

The patient is scheduled for a follow-up appointment on [Date]. Please contact our office at [Phone Number] if you observe any changes in seizure frequency, duration, or behavior during school hours.

Sincerely,

[Physician Signature]

[Physician Name, Title]

[Clinic Name]

[Contact Information]