[Physician Name/Clinic Name]
[Address]
[Phone Number]

[Date]

To: [School Name/School Administration]

Re: [Student Name]
Date of Birth: [DOB]

To Whom It May Concern,

The above-named student was evaluated following a seizure event that occurred on [Date of Event].

I have determined that the student is medically cleared to return to school effective [Date].

The student may participate in all school activities, including Physical Education, sports, and extracurricular events, without any restrictions or limitations. No specific modifications to the student's academic schedule or physical environment are required at this time.

Please refer to the student's Seizure Action Plan on file for standard emergency protocols.

If you have any questions or require further documentation, please contact my office.

Sincerely,

[Physician Signature]
[Physician Printed Name]
[Medical License Number]