Date: [Date]

To: [School Name / School Nurse Name]
From: [Healthcare Provider Name/Clinic]
Subject: Medical Clearance for Return to School

Student Name: [Student Full Name]
Date of Birth: [Student DOB]
Date of Event: [Date of Seizure]

To whom it may concern,

[Student Name] has undergone a medical evaluation following their recent first-time seizure event. Based on my clinical assessment, the student is medically cleared to return to school on [Return Date].

Activity Restrictions:
[Insert specific restrictions, e.g., No swimming, no climbing heights, or 'No restrictions']

Seizure Rescue Medication:
[ ] No rescue medication prescribed at this time.
[ ] Rescue medication prescribed: [Medication Name/Dosage/Instructions]

Emergency Protocol:
Please refer to the attached Seizure Action Plan for specific instructions regarding seizure management and when to activate Emergency Medical Services (EMS).

If you have any questions regarding this evaluation or the student's care, please contact my office at [Phone Number].

Sincerely,

[Provider Signature]
[Provider Printed Name]
[Credentials]
[Clinic/Hospital Name]