[Clinic or Hospital Name]
[Street Address]
[City, State, Zip Code]
[Phone Number]

Date: [Current Date]

To: [School Name or School Nurse]
Subject: Immunization Verification for [Patient's Full Name]

RE: [Patient's Full Name]
Date of Birth: [Patient's Date of Birth]

To Whom It May Concern,

This letter is to verify that the above-named patient is currently under my care and is up to date with all required immunizations according to the state and federal health guidelines for their age group.

The patient received the following vaccinations/updates today:

- [Vaccine Name 1]
- [Vaccine Name 2]

Based on their current vaccination status, the student is medically cleared to return to school and participate in all school-related activities starting on [Return Date].

Official immunization records are attached to this letter for your files. Please contact our office at [Phone Number] if you require any further documentation or have questions regarding this student's health status.

Sincerely,

[Physician's Signature]
[Physician's Printed Name]
[Medical License Number]
[Clinic Stamp]