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

To: [School Name / To Whom It May Concern]
Subject: Certificate of Immunization and School Attendance Clearance

Student Name: [Student Full Name]
Date of Birth: [Date of Birth]
Grade Level: [Grade]

To Whom It May Concern,

This letter serves to certify that the above-named student is a patient at [Clinic Name]. We have reviewed the student's immunization records and can confirm the following:

[Select one option and delete the others]:

- The student is up-to-date on all immunizations required by the state for school attendance.
- The student has received the required initial doses and is currently on a catch-up schedule. The next appointment is scheduled for [Date].
- The student has a medical exemption for the following vaccine(s): [List Vaccines].

Based on our records, this student is medically cleared to attend school and participate in all school-related activities.

A copy of the official [State/Registry Name] Immunization Record is attached to this letter for your files.

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

Sincerely,

[Signature of Healthcare Provider]
[Printed Name of Healthcare Provider]
[Title: e.g., MD, NP, PA]
[Clinic Stamp]