

Date: [Date]

To: [School Name/School Nurse]

Re: Medical Clearance for [Student Name]

Date of Birth: [Student Date of Birth]

To Whom It May Concern,

This letter is to certify that [Student Name] was seen and treated for an asthma exacerbation on [Date].

The student is now medically cleared to return to school and resume full classroom activities on [Return Date].

Physical Activity Status:

- May participate in full physical education and sports without restrictions.
- May participate in physical activity with the following restrictions: [List Restrictions].
- No physical activity until [Date].

Medications and Action Plan:

- An updated Asthma Action Plan is attached.
- The student is cleared to self-carry and self-administer their rescue inhaler.
- The student requires assistance with their inhaler as per the attached instructions.

Please contact my office at [Phone Number] if you have any questions or require further documentation.

Sincerely,

[Physician Name/Signature]
[Medical Practice/Clinic Name]
[Phone Number]