

[Doctor's Name/Clinic Name]  
[Clinic Address]  
[Phone Number]  
[Date]

To: [School Name/Principal Name]  
[School Address]

**RE: Medical Clearance for [Student Name]**

To whom it may concern,

This letter is to certify that [Student Name], date of birth [DOB], has been under my care for an extended illness from [Start Date] to [End Date].

After a clinical evaluation, I have determined that the student has recovered sufficiently to return to school safely. [Student Name] is no longer contagious and is medically cleared to resume full academic activities effective [Return Date].

**Activity Restrictions:**

- No restrictions; the student may participate in all activities including PE.
- The student has the following temporary restrictions: [List restrictions, e.g., no heavy lifting, limited physical activity] until [Date].

**Medication/Accommodations:**

[List any necessary medications to be administered at school or special accommodations needed, or write "None"].

If you require any further information, please contact my office.

Sincerely,

[Doctor's Signature]  
[Doctor's Printed Name]  
[Medical License Number]