

Date: [Insert Date]

Subject: Medical Clearance for Return to School/Work

Patient Name: [Insert Patient Name]

Date of Birth: [Insert Date of Birth]

To Whom It May Concern,

This letter is to certify that the above-named patient was under my medical care for a gastrointestinal illness. The patient has been evaluated and is now considered recovered from the infectious period.

Based on current clinical guidelines, the patient meets the following criteria for discharge and clearance:

- The patient has been fever-free for at least 24 hours without the use of fever-reducing medication.
- Symptoms, including vomiting and diarrhea, have resolved for at least [24/48] hours.
- Laboratory tests (if applicable) indicate the patient no longer poses a significant risk of transmission.

The patient is cleared to return to [Work/School/Childcare] effective [Insert Date] with no restrictions on activities.

If you require further information, please contact my office at [Insert Phone Number].

Sincerely,

[Physician Signature]

[Physician Name, MD/DO]

[Facility Name]

[License Number]