Date: [Insert Date]

To: [Recipient Name/Organization]
Subject: Medical Evaluation of Severe Post-Vaccination Reaction

Patient Name: [Patient Full Name]
Date of Birth: [MM/DD/YYYY]
Date of Vaccination: [Insert Date]

To Whom It May Concern,

I am writing to provide a formal medical evaluation for the aforementioned patient regarding a severe adverse reaction following the administration of the [Insert Vaccine Name] vaccine.

Clinical Presentation:
The patient presented on [Date] with the following symptoms: [List symptoms, e.g., anaphylaxis, neurological impairment, severe inflammation]. These symptoms manifested [Number] hours/days after vaccination.

Diagnostic Findings:
Based on clinical examination and diagnostic testing ([List tests, e.g., blood work, MRI, ECG]), it has been determined that these symptoms are clinically consistent with a severe post-vaccination reaction.

Medical Assessment:
[Describe the severity and impact on the patient's health or ability to work/study]. Due to the nature of this reaction, the following medical recommendations are in place:

- [Recommendation 1, e.g., Immediate medical leave]
- [Recommendation 2, e.g., Contraindication for future doses of this vaccine type]
- [Recommendation 3, e.g., Ongoing specialist referral]

The patient is currently under my care and is being monitored for [Mention duration or expected recovery timeline].

Please contact my office at [Phone Number] if further clarification is required.

Sincerely,

[Doctor's Signature]
[Doctor's Name, MD/DO]
[Medical License Number]
[Clinic/Hospital Name]