Date: [Insert Date]

Patient Name: [Insert Patient Name]
Date of Birth: [Insert Date of Birth]
Patient ID: [Insert ID Number]

To Whom It May Concern,

The above-named patient was evaluated by my office following an adverse reaction to their first dose of the [Insert Name of Vaccine] vaccine, which was administered on [Insert Date of First Dose].

The reported reaction consisted of: [Insert Brief Description of Symptoms].

After a clinical review of the patient's symptoms and medical history, I have determined the following:

- The patient has been medically cleared to receive the second dose of the vaccine.
- The reaction was deemed non-anaphylactic and does not pose a contraindication to further doses.
- [Optional] It is recommended that the second dose be administered in a setting with medical supervision and a [Insert Time, e.g., 30-minute] observation period.

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

Sincerely,

[Physician Signature]
[Physician Name, MD/DO]
[Medical License Number]
[Clinic/Facility Name]