Special School District Health Services

Return to School Following Hospitalization, Serious Illness and/or Injury

Student's Name: _____ DOB: _____

Guardian Signature & Date:_____

PCP, Specialist, or other MD/DO to Complete this Section:

Diagnosis or reason for recent illness/hospitalization:

_____

_____

_____

Date student may return to school: _____

If student requires nursing care at school, please list any new nursing orders including medications, treatments or procedures that must be provided during the school day:

_____

_____

_____

If student receives Physical Therapy and/or Occupational Therapy at school, please indicate any changes in PT and/or OT orders (may be no changes):

_____

_____

_____

Next scheduled office/clinic visit: _____

Restrictions:_____

Provider's Name: _____ Signature:_____