MEDICAL CLEARANCE TO RETURN TO SCHOOL AFTER MEDICAL OR SURGICAL HOSPITALIZATION

NAME:_____DOB:_____

Date the student is cleared to return to school:_____

1. Admission Diagnosis:_____
2. If student had surgery, what procedure was done:_____

   _____

   Please note any medical procedures done:_____
3. What precautions/restrictions are needed in school – Please check all below that apply:
   a. Weight bearing status:

      Upper extremities

      Lower extremities

   b. Range of Motion Limitations:

      Upper Extremities

      Lower Extremities

   c. Positioning Limitations: (Please note what the restriction is and how long it will be in place)

      Stander

      Wheelchair

      Positioning Chair

      Floor Sitting

      Adaptive Toilet

      Gait Trainer

d. Transfer/Lifting Precautions:

4. May the student resume Physical/Occupational Therapy as recommended in the current IEP? Yes/No
   If no, when can the therapy resume?_____
5. May the student resume swimming in the school pool? Yes NO
   If no, when can they resume ? _____
5. Will the student require medications at school Yes/No
   If yes please complete a request to Administer medication at school form (attached)
6. Are there changes to the students current feeding plan? Yes/No

Date (s) of Follow up appointment(s) and with whom:

_____

Physician Name (please print)

Office Address:

Office Phone number:_____

Fax Number:_____

_____ _____

Physician Signature Date