Health Care Provider's Orders for Student to Receive Services/Return to School Following Hospitalization or Surgery

Date:____________________

Student's Name:____ Grade:_____________

Student may return to school on: (date)_____________________________

Surgical procedure:____

(or) Reason for hospitalization:____

Ambulatory status:____

Weight bearing status:____

Restrictions for school day:____

Restrictions for gym/recess:____

Any special issues for educational tasks:____

____

Resume all previous Dr's orders: (circle one) Yes No

Any other new orders:____

____

Health Care Provider's Name:___________________________
Phone Number:____

Health Care Provider's Signature:________________________

Thank you,

________________________ / School Nurse