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

Rev. 7/14