Franklin County Schools

School Health Services

Return to School after Surgery/Extended Illness

Physician Authorization Form

Date: _____

This letter is to signify that _____ (DOB: _____) is ready to return to school on this date _____.

Diagnosis/Surgery: _____

Recommendations for School:

- ☐ No restriction of activity/no modifications needed
- ☐ No gym/sports for (#) _____ weeks
- ☐ No recess
- ☐ Needs assistance between classes, i.e. needs help carrying books
- ☐ Set of extra books for home use recommended
- ☐ May need a modified day; explain: _____
- ☐ Needs assistance with toileting
- ☐ Needs assistance with transfers, i.e. from chair to floor, from wheelchair to toilet
- ☐ Diet order (nurse will send diet order to be filled out)

Equipment (not provided by school):

- ☐ No equipment needed
- ☐ Crutches
- ☐ Braces
- ☐ Wheelchair
- ☐ Cast
- ☐ Walking (CAM) boot
- ☐ Other: _____
- ☐ # of _____ weeks

Any further restrictions or modifications needed at school:_____

_____

Physician's Signature: _____ Date: _____

Physician's Name: _____ Phone: _____

Parent Signature: _____ Date: _____

Parent Phone Number: _____

School Nurse Signature: _____ Date: _____