BLAIR ACADEMY J. BROOKS HOFFMAN ' 36 HEALTH CENTER
2 PARK STREET, BLAIRSTOWN, NJ 07825 PHONE: (908)362-2010 FA X: (908)362-7885

OFF CAMPUS HEALTH CARE PROVIDER FORM 2024-2025

To the **EXAMINING HEALTH CARE PROVIDER:**
In order to ensure that the Health Center has a completed and updated health record for our mutual patient/student and for communication purposes if the Health Center has a question, please complete the information below and STAMP in the space provided.
Please present this completed form, along with the medication (if applicable), to the Health Center upon arrival at school.

Date: ______________________________ Student Name: _____________________________

Diagnosis:: ____________________________ Date of Birth: _______________________________

Treatment*:* _____________________________ Plan of Care: ______________________________

Follow up Appointment*?* ❏ NO ❏ YES (date) ________________________

Activity Level: *Consulting Healthcare Provider MUST designate below:*
❏ No activity*: Complete restriction from physical activity until* (*date)*
***A written health care provider's note of Clearance must be received by the Health Center BEFORE student will be permitted to return to activities*
❏ Partially cleared as of _________________________(date) with restrictions/allowances listed here:
____
____
❏ Cleared for FULL activity as of _________________________________*(date)*

Rehabilitation Program: *Consulting Healthcare Provider Must designate below:*
❏ Student referred to Physical Therapy (please provide written prescription)
❏ No physical therapy or rehabilitation recommended at this time.
❏ May work with school's certified athletic trainers
❏ Surgery recommended/schedule _______________(date)

MD / D O / PA / NP Print Name

MD / D O / PA / NP Sign and D ate

Address

Phone and Fax Number

Office Stamp (Required)