GWINNETT COUNTY PUBLIC SCHOOLS
HEALTH AND SOCIAL SERVICES

Physician Report After a Prolonged Hospitalization/Surgery

School Year: _____

(Please answer the items below to help us plan the best school program for this student)

STUDENT NAME: _____ DOB: _____
SCHOOL: _____ STUDENT ID: _____

Reason for student evaluation/hospitalization/surgery: _____
_____

Recommendations at school:

1. **Date student may return to school:** _____
2. **Clinical manifestations/symptoms to observe for as related to student's condition:**
   _____
   _____
3. **Specific recommendations:**
   a. **Dietary:** _____
   b. **Activity Restrictions**:_____
      _____
   c. **Treatment:** _____
      _____
   d. **Current Medications:** _____
      _____
   e. **Call 911 if:** _____
   f. **Other:** _____

_____ _____
Physician Name (Please Print) **Physician Phone Number**

_____ _____
Physician Signature **Date**

TO WHOM IT MAY CONCERN:

I hereby give my permission for exchange of confidential information requested above for my child, _____, between _____ and _____.

_____ _____
Signature of Parent/Guardian Date

PLEASE RETURN TO: Oakland Nurse
FAX:770-513-6803

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