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 2025-2026

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)