

MEDICAL CLEARANCE TO RETURN TO SCHOOL AFTER MEDICAL OR SURGICAL
HOSPITALIZATION

NAME: _____ DOB: _____

Date the student is cleared to return to school: _____

1. Admission Diagnosis: _____

2. If students had surgery, what procedures were done:

Please note any medical procedure was done: _____

3. What precautions/restrictions are needed in school- Check all that apply below:

A. Weight bearing status:

- ☐ Upper Extremities
- ☐ Lower Extremities

B. Range Of Motion Limitations:

- ☐ Upper Extremities
- ☐ Lower Extremities

C. Positioning Limitations: (Please note what the restriction is and how long it will be in place)

- ☐ Stander
- ☐ Wheelchair
- ☐ Positioning Chair
- ☐ Floor Sitting
- ☐ Adaptive Toilet
- ☐ Gait Trainer

D. Transfer/Lifting Precautions:

4. May the student resume Physical/Occupational Therapy as recommended in the current IEP? YES OR NO

If not, when can the therapy resume? _____

5. May the student resume swimming in the school Pool? YES OR NO

If not, when can they resume? _____

6. Will the students require medication at school? YES OR NO

If yes, please complete a request to Administer Medication at school form (Attached)

7. Are there changes to the student current feeding plan? YES OR NO

List the dates of the follow-up appointments and with whom:

Physician Name (Print): _____

Office Address: _____

Office Phone Number: _____

Fax Number: _____

Physician Signature: _____ Date: _____