Release to Return to School

This form must be completed and signed by the treating physician

Student ID:_________________________

Student:_______________________________Grade:____ School:_________________

The above names student has been under my care from: __________to__________

Specify Student's Medical Diagnosis:____

Has the physician or mental condition stabilized or remediated? ☐ Yes ☐ No
If no, please explain.

Has the student been discharged from your care? ☐ Yes ☐ No

If yes, what date was the student discharged? _____________

If no, when will the student return for follow-up and final release?____________

Is the student returning to school from Caring Hearts/PPEC (Prescribed Pediatric Extended Care)? ☐ Yes ☐ No

May the student participate fully in all school activities? ☐ Yes ☐ No
If no, Indicate necessary restrictions:

Does the student require any medications while at school? ☐ Yes ☐ No
If yes, please complete a Medication Authorization Form for each required medication. Direct link to form: English Spanish Creole

Does the student require any medical treatments or procedures at school? ☐ Yes ☐ No
If yes, please complete the Authorization form Nursing Care and Treatment Form, describing the medical treatments or procedures that need to be done at school.
Link to form: Authorization for Nursing Care & Treatment

____________________________ ____________________________
Type or Print Physician's Name Physician's Signature

_________________ _________________ ______________________
Telephone # Fax # Date