RETURN TO SCHOOL AFTER MEDICAL HOMEBOUND SERVICES

I. **STUDENT INFORMATION (Please Print)**

Student's Name:	Date of Birth:	Age:	Grade:
School:	School Year:	Parent Name: Parent Phone number:	

II. Dear Dr. _____

Your patient is reentering the Horry County School District after a Medical related absence. We need information concerning his/her health status. Please complete the information requested below.

III. **PERMISSION TO RETURN TO SCHOOL**

_____ can return to school on ___/___/___
(Student Name) Date

IV. **Current Diagnosis and Medical Status:** (additional information may be attached to this form)

_____

_____

V. **Recommendations for Student Integration into the School Setting**

Activity Restrictions: _____

Nutritional/Dietary: _____

Adaptive Physical Education: _____

Occupational Therapy _____

Physical Therapy _____

Special Procedures _____

_____ _____ ___/___/___
Physician Name (Printed) Physician Signature Date

Physician Address_____ Phone: _____
_____ Fax: _____

_____ _____ ___/___/___
Parent/Guardian Name (Printed) Parent/Guardian Signature Date

Cc: parent
DO