ELIM CHRISTIAN SCHOOL

RETURN TO SCHOOL PERMISSION FORM

IF RESTRICTIONS ARE REQUIRED OR IF THERE IS A CHANGE IN MEDICAL STATUS
THIS FORM SHOULD BE RECEIVED BY ELIM 24 HOURS PRIOR TO THE STUDENT'S RETURN TO SCHOOL.
PLEASE COMPLETE THIS FORM IN ITS ENTIRETY

Student Name:_____ Date:_____

Diagnosis/Description of Illness/Injury:_____

Discharge date:_____ Date student may return to school:_____

Please include specific instructions for any restrictions.

Ambulation: ❑ Yes ❑ No Wheelchair usage: ❑ Yes ❑ No

Weight Bearing Status:_____

Specific Instructions:_____

Physical Therapy: Restrictions ❑ Yes ❑ No

Specific instructions_____

Occupational Therapy: Restrictions ❑ Yes ❑ No

Specific instructions_____

Physical Education (Adapted P.E.): Restrictions ❑ Yes ❑ No

Specific instructions _____

Swimming: Restrictions ❑ Yes ❑ No

Specific instructions_____

Recess: Restrictions ❑ Yes ❑ No

Specific instructions_____

Toileting/Transfer:
Specific Instructions:_____

Psychiatric Hospitalization ❑ Yes ❑ No
If applicable, please explain the impact medication changes may have on the student's behavior:_____
_____

Physician's name (please print):_____ Physician's Signature:_____

Physician's office phone #_____ Fax #_____

Any changes to medication, seizure action plan, or diet order will require additional documentation.
All forms are available for download at www.elimcs.org
Please return completed form to the Elim Christian School Nursing Office
Phone: (708) 389-0555 Ext: 305 Email: nurse@elimcs.org Fax: (708) 293-2355 **Revised: 07/28/2015**