



**ELIM CHRISTIAN SCHOOL
RETURN TO SCHOOL PERMISSION FORM**

THIS FORM MUST BE SUBMITTED 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: 08/22/2019