ELIM CHRISTIAN SCHOOL

RETURN TO SCHOOL PERMISSION

THIS FORM MUST BE SUBMITTED 24 HOURS PRIOR TO THE STUDENT'S RETURN TO SCHOOL.

Student Name:_____ DOB:_____ 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 _____

_____

Recess: Restrictions ❑ Yes ❑ No

Specific instructions_____

_____

Feeding/Eating: Restrictions ❑ Yes ❑ No

Specific instructions_____

_____

Toileting/Transfer: Restrictions ❑ Yes ❑ No

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 etc. may require additional documentation.

Discharge summary may also be requested. 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: 9/24/26