



Washington County School District Health Services

MEDICAL RELEASE TO RETURN TO SCHOOL FOLLOWING SURGERY/INJURY

Student's Name _____ School _____

Medical Diagnosis _____

Medical Procedure _____ Surgical Date _____

Return to School Date _____

To assure a safe, injury-free transition back to school, it is recommended that students requiring pain medication not return to school until their incisions are healed.

Check the responses which apply below:

- | Yes | No | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Student may return to school without activity restriction |
| <input type="checkbox"/> | <input type="checkbox"/> | Physical activity limitations recommended at school |
| | <input type="checkbox"/> | Limited mobility at school _____ |
| | <input type="checkbox"/> | Limited or restricted P.E. participation _____ |
| | <input type="checkbox"/> | Limited or non-weight bearing _____ |
| | <input type="checkbox"/> | Requires use of elevator |
| | <input type="checkbox"/> | Set of extra books for home use recommended |
| | <input type="checkbox"/> | Needs assistance between classes |
| | <input type="checkbox"/> | Other _____ |

Special equipment required:

- | | | |
|--------------------------------------|---------------------------------|-------------------------------|
| <input type="checkbox"/> Wheelchair | <input type="checkbox"/> Brace | <input type="checkbox"/> Cast |
| <input type="checkbox"/> Crutches | <input type="checkbox"/> Walker | |
| <input type="checkbox"/> Other _____ | | |

Additional Information _____

Post Surgery:

- | Yes | No | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | Pain medication required _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Sutures/staples removed |
| <input type="checkbox"/> | <input type="checkbox"/> | Incision intact without infection or risk of opening |
| <input type="checkbox"/> | <input type="checkbox"/> | MD follow-up appointment completed. Next appointment: _____ |

PHYSICIAN INFORMATION:

Physician's Signature _____

Physician's Name (Printed) _____ Phone _____

Address _____ Date _____

PLEASE RETURN THIS FORM TO THE SCHOOL NURSE