**SC School for the Deaf and the Blind**
355 Cedar Springs Road, Spartanburg SC 29302
864-577-7780 • Fax 864-577-7629

# Medical Release to Return to School

**Instructions:** This form is to be completed and **signed by the student's treating physician**. It is designed to facilitate the most comfortable transition possible for student's return from surgeries, medical procedures and/or extended medical absences. Please ***attach prescriptions*** for needed medications, treatments, physical or occupational therapy and equipment. Ideally, **the form should be returned 3 days in advance of student's return** so that necessary arrangements can be made. If not returned timely, the student's return to school may be delayed. **Note: Blank spaces indicate there are no needs in that area.**

**Student Name** ______________________________ **DOB** ______________

Type of surgery or procedure, or reason hospitalized ______________________________

______________________________________________________________

Date of surgery,
procedure, or hospitalization: Date to return to school:

**Doctor's Name**: ______________________________ **Phone** ______________________

**Address** ______________________________ **Fax** ______________________

**City, State, Zip** ______________________________ **Email** ______________________

**SCHOOL Restrictions/**Special Instructions ______________________________

Extra assistance needed in school ______________________________

**DORM Restrictions/**Special Instructions ______________________________

Extra assistance needed in dorm______________________________

**MEDICAL Restrictions/**Special Instructions ______________________________

*New Meds, Treatments, Procedures ______________________________

***WOUND CARE/** DRESSING CHANGE
Instructions**:** ______________________________

***DIET Restrictions/**Special Instructions ______________________________

**MENTAL HEALTH needs** (ex: counseling, increased supervision) ______________________________

**PE/ATHLETICS Restrictions, Orders, Instructions**
(Sports, Swimming, Therapeutic Horseback riding): ______________________________

______________________________________________________________

***THERAPY ORDERS** (PT/OT/ST)**:** ______________________________

****ATTACH ORDERS***

Duration of these instructions: ______________________ Next Appointment ______________

Physician Signature ______________________________ Date ______________