PILLAR
CARE CONTINUUM
Lifelong Support for People with Disabilities

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MEDICAL CLEARANCE TO RETURN TO SCHOOL AFTER HOSPITALIZATION

Hospital Discharge Summary must accompany this form

Student's Name: _____DOB: _____

Reason for Hospitalization / Diagnosis(s): _____

Date(s) of Hospitalization: _____

Additional Information: _____

_____

Nursing

Medication(s):_____

_____

Any new care parameters: _____

_____

Physical Therapy (check all that apply)

____Not cleared to return to therapy.

____May return to therapy **without** restrictions.

____May return to therapy **with** the following restrictions (Please be specific):

Range of Motion: _____

Weight Bearing_____

Bracing: _____

Equipment: _____

Positioning: _____

Additional: _____

Occupational Therapy (check all that apply)

____ Not cleared to return to therapy.

____ May return to therapy **without** restrictions

____ May return to therapy **with** the following restrictions (Please be specific):

Additional: _____

Speech Therapy (check all that apply)

____ Not cleared to return to therapy

____ May return to therapy **without** restrictions

____ May return to therapy **with** the following restrictions (Please be specific):

Feeding: _____

Physician Signature: _____ **Parent Signature**: _____

Date: _____ **Date:** _____

Phone No: _____ **Phone No:** _____