



Medical Authorization Return to School

Child's Name: _____

Date: _____ DOB: _____

_____ may return to school and participate in the
program on _____ .
date

Assessment/Diagnosis: _____

Procedure/Treatment: _____

MD/NP Name: _____

Phone Number: _____

Activity Restrictions/Contra-Indications: _____

Resume school medications

Resume ST/OT/PT- all therapies

Will child need treatment or medication at school? Yes No

Treatment Plan/Orders: _____

MD/NP Signature

Date