LABBB Health Office at Lexington High School
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Tel: 781-861-2400 ext 1009
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Post-Illness or Hospitalization Return to School Form

Student name: _____ DOB: _____

Student is s/p: _____

_____

_____

New medications or changes: _____

_____

Weight-bearing status: _____

Please check yes or no for each activity:

	Yes	No
Student may participate in vocation activities (work)		
Student may participate in off-campus field trips		
Student may walk approximately one mile with classmates and staff		
Student may participate in physical education classes		
Student may participate in swimming		
Student may participate in physical therapy sessions		
Student may walk up and down stairs		
Student may participate in after-school recreational activities (i.e. golf, bowling)		

Additional considerations: _____

_____

Date and location of follow up appointment: _____

Provider signature: _____ **Date:** _____

Provider name: _____ **Credentials:** _____

Hospital Affiliation: _____ **Phone:** _____