LABBB Health Office at Lexington High School
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Post-Illness or Hospitalization Return to School Form

Student :_______________________________________ DOB: _______________________

Student is s/p: ____

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____

New medications or changes: ____

____

Please check yes or no for each activity:

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

Additional Considerations:____

____

Date and location of follow up appointment: ____

Provider Signature: ___________________________ Hospital Affiliation :______________________

Provider Name: ______________________________ Credentials: ________ Phone: _____________