The Children's Learning Center
380 Washington Avenue, Roosevelt, New York 11575-1899, CLC Nursing Office: (516) 378-2000, ext. 280, Fax: (516) 377-2081

Return To School Clearance/ Resume Therapies Form

The following are reasons why your child is required to have this form completed to return to school and resume therapies: Please take note, in order for your child to safely participate in his/her school activities, CLC may request additional medical information needed to fully clear your child to come back to school and continue therapies:

- Absent for 5 days or more due to illness
- Sent to the emergency room
- Admitted to the hospital
- Post surgery
- Inpatient labs/testing, examples: EEG, EKG, Sleep study, MRI **(only needed if results are abnormal)**
- Diagnosed with and/or treated for a communicable disease/contagious virus or bacterial infection, including but not limited to: German Measles, Measles, Chicken Pox, Mumps, Ring Worm, Whooping Cough, Coxsackie Virus, Conjunctivitis, Fifths Disease, Strep Throat

*Parents: Please have a physician, physician assistant or nurse practitioner fill this out, sign, date and stamp it. When it is fully completed, form should be sent to the nursing office BEFORE your child returns to school. Please note: Completed form can be faxed from the doctor's office to the CLC nursing office at 516-377-2081.

Student Name: _____ **Date Cleared to Return to School**: _____

Reason(s) why the student was absent: _____

_____

- As a result of his/her absence is he/she receiving medications/treatments at this time? YES/ NO
- If so, what medications/treatments? _____
- A prescription is required for all medications/treatments needed to be administered at school.
- If student was admitted to the hospital or is post surgery, what are his/her diagnosis and what procedure was performed?

_____

THERAPY CLEARANCE: Indicate Date Cleared To Resume Therapies & Any Restrictions OR Therapy Recommendations:

- **Adaptive Physical Education:** _____
- **OT:** _____
- **PT:** _____
- **ST:** _____

For issues related to feeding, including swallow studies, please indicate any changes in diet consistencies/feeding precautions: _____

- **Other:** _____

_____ _____

CLC Nursing Signature **Date**

ONLY COMPLETE THIS BOX FOLLOWING ORTHOPEDIC ISSUES / ORTHOPEDIC SURGERY:

Physical Therapy Clearance:	**For S/P Spine & LE Injury/Procedures:** **Circle Weight Bearing Status:** **NWB WBAT PWB FWB**
Indicate Date Cleared To Resume PT:	**Indicate Specific Equipment Restrictions (i.e. orthotics, standers, walkers):**
Indicate Specific Treatment Restrictions in PT:	**Other Important Information:**
Indicate Specific PT Treatment Recommendations:	

Print Physician Name: _____ Telephone#: _____

Physician Signature: _____ Date: _____

Physician's NPI #: _____ Physician's License #: _____

Physician Stamp: