

\*Required prior to student's return to school after hospitalization. Doctor may use their own form.

## **DISCHARGE SUMMARY**

**To the Physician:** In order to assure Cotting students are receiving the highest care possible, we must ask that you complete this discharge summary and indicate any changes, limitations or precautions which should be incorporated in the child's school program services.

\_\_\_\_\_ is able to return to school as of \_\_\_\_\_.  
Student's Name Date

Reason for absence: \_\_\_\_\_.

Date and type of surgery: \_\_\_\_\_.

### **Medical/Nursing Services**

\_\_\_ This student has a medication change. A signed, medication order is attached.

\_\_\_ This student requires treatment(s) or dressing changes in school. A signed order is attached.

\_\_\_ This student is now on a special diet, or has the following modifications or restrictions related to feeding: \_\_\_\_\_

\_\_\_ This student has the following modifications or restrictions related to toileting: \_\_\_\_\_

\_\_\_ This student has other modifications or restrictions, which consist of: \_\_\_\_\_

\_\_\_ This student may return without any modifications or restrictions.

### **Physical/Occupational Therapy Services**

\_\_\_ This student may return with the following modifications or restrictions: \_\_\_\_\_

\_\_\_ The following limits on mobility should be set for this student: (walking, standing, running, stretching, strengthening, lifting, exercise, adapted physical education, etc.) \_\_\_\_\_

\_\_\_ This student may fully weight bear

\_\_\_ This student may partially weight bear: \_\_\_\_\_

\_\_\_ This student should be non weight bearing until: \_\_\_\_\_

\_\_\_ The following precautions shall be taken when transferring this student: \_\_\_\_\_

\_\_\_ This student may return without any modifications or restrictions.

**Other Considerations for School Program:** \_\_\_\_\_

**This student \_\_\_\_\_ is \_\_\_\_\_ is not fit to work at his or her in house job or off-campus job.**

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Phone Number

\_\_\_\_\_  
Physician's Name Printed

\_\_\_\_\_  
Date

**I give my permission for Cotting School's Nurses to contact the Physician with any questions related to this Discharge Summary.**

\_\_\_\_\_  
Parent's Signature

\_\_\_\_\_  
Date