ARLINGTON HEIGHTS SCHOOL DISTRICT 25

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Assistant Superintendent for Student Services
Aimée LeBlanc

Student Services Coordinators
Lindsay Anastacio
Ginny Hiltz
Diane Kaffka
Lisa Kramp

Student Services Administrative Assistant
Ginny Braun

Student Services Secretary
Diane Carpenter

Early Childhood Secretary
Karen Pilli

RETURN FROM SERIOUS INJURY OR ILLNESS FORM

Completed form must be returned to the nurse on student's first day back to school

School ______________________________ **Return Date** ______________________________

Name of Student ____

Address ____

____

Age Grade Sex Home Phone Number

Diagnosis ____

SPECIFIC INSTRUCTIONS

1. Physical Limitations (PE, movement in hall, need for elevator use, etc.)______________________________

   ____

   ____

2. Full or partial schedule: ____

   ____

3. Other special needs: ____

MEDICATIONS

(ONLY IF REQUIRED DURING SCHOOL DAY)

Medication and Dosage	Time of Administration	Possible Side Effects

Other medications student is receiving: ____

____

I certify that the above named student under my care is medically able to return to school with the limitations, restrictions, and/or medications as indicated.

______________________________ ______________________________
Physician Signature Parent/Guardian Signature

______________________________ ______________________________
Phone number Relationship

______________________________ ______________________________

For Success and Understanding