Return to School Nurse:
251 Stonehaven Road
Fall River, MA 02723
508-678-2891 ext. 1770
Nurse Fax 508-674-3263

Release to Return to Participate in Vocational Educational Setting

Please note student safety is a paramount concern. Activity in a vocational technical education program is unlike participation in a traditional academic classroom and students spend 2 weeks in their vocational program at one time. To that end, we require that students ***returning to school after NON-ROUTINE medical treatment***, of any kind, (including but not limited to an emergency room visit, mental health assessment, or hospitalization) ***must provide medical documentation*** of the student's condition, clearance for reentry to school, and any limitations.

Name of Student	ID #	Vocational Program
Medical Diagnosis/Treatment:		

Please complete the following information and return to the fax number above.
All sections must be filled in, signed, and dated.

1. **Is the student safe to return to the vocational education setting**? Y ☐ N ☐ **Date:** _____
Next Appointment Date: _____

2. **Student is released to:**

☐ full participation without limitations **Date:** _____

☐ modified participation from (date): _____ through (date): _____

☐ modified hours – specify: from (date): _____ through (date): _____

3. **Specify limitations below:**

Identify any factors/medications/conditions that would impair the student's ability or judgement while working with heavy machinery (such as drills, electric saws, torches, cutlery, ovens, stoves, etc.) and the corresponding limitations with dates.
If none, write "none".

4. **Medications prescribed.** ☐ **Yes** ☐ **No**

Medication	Dosage	Administered at school? Time	Limitations for operating machinery	Side Effects

5. **Physical Demands and Activities**

	Yes	No	If no, list Limitations		Yes	No	If no, list Limitations
Bending				Pushing and Pulling			
Carrying				Reaching			
Climbing Ladders				Reaching Overhead			
Climbing Stairs				Sitting			
Fingering				Standing			
Lifting Floor to Waist				Squatting			
Lifting Overhead				Computer use			

Signature of physician/clinician	**Printed physician/clinician name**	**Date**

For Administrative Use Only

Received By:	Date Received:	Date Expires: