Essential Rheumatology LLC
860-325-6908

Return-to-School Clearance Form

Student Information

Student Name: _____ Date of Birth: _____

Date of Evaluation: _____ Diagnosis/Condition: _____

School Name: _____ Grade: _____

School Clearance

☐ **Full participation — no restrictions**

☐ **Modified participation (see below)**

☐ **Not cleared to return to school at this time**

Effective Return Date: _____ Duration of Restrictions: _____

Restrictions (if applicable)

_____

_____

_____

_____

Follow-Up & Provider Certification

Next Appointment: _____ Re-evaluation Required: _____

I certify that the above-named student has been evaluated and the information provided is accurate to the best of my clinical judgment.

Provider Name (Print): _____ Credential: _____

Provider Signature: _____ Date: _____