DACC | DELAWARE AREA CAREER CENTER

Post-Hospitalization and/or Outpatient Care Report to School

Student's Name: _____ DOB: _____

School District_____ Grade:_____

Reason for hospitalization or diagnosis:_____

Date student may return to school:_____

Need for homebound instruction or modified day (How long?):_____

Recommendations for health management at school:_____

1. Symptoms you may observe, related to student's condition:

   Observation_____Action: (CP-Call Parent), EASP- See Emergency Action Plan, N-None)

   _____

   _____

2. Medications: (It is helpful for the school nurse to know all the meds, in case side effects occur.)

   None_____

   List: Medication name, Dose, Route, Time(s) to be given, Special Instructions:

   _____

   _____

3. Other Recommendations:

   Special Diet_____ Need for extra hydration:_____

   Activity Restrictions:_____ PE:_____

   Positioning:_____ Special Toileting Needs:_____

   Treatments/Procedures (if done at school, please attach signed orders, with specifics)

   _____

   _____

   Special Equipment:_____

   Other:_____

Nurse (DACC Healthcare Professional): Name:_____ Phone:_____

Physician/Healthcare Provider: Name:_____ Phone:_____

Physician/Healthcare Provider Signature:_____ Date:_____