RETURN FROM MEDICAL LEAVE
MEDICAL UPDATE FROM PROVIDER

Student: ____________________________

Name of Provider(s):

Address:

Phone:         Fax:
Email:

Date(s) of care:

What was the initial diagnosis or health problem?

What changes have occurred that will enable the student to return successfully to Carleton?

Please list all current medications/therapies:

What will the student need to manage this health situation once returned to Carleton?
(For example: medication, appointments off campus, reduced academic load, support from Academic Support Center, Disability Services, Dean of Students, Student Health and Counseling, etc.)

Will the student follow up with you or other healthcare providers while at Carleton or when the student returns home for breaks? If so, how can we best collaborate in this patient’s care?

Do you support the decision of this student to return to campus?
Yes _________             No ____________

Signature of Provider ___________________________________             Date ____________________