Practical Nursing Program
Medical Permission to Return to Classroom/Clinical

Student Name: _____ **Date:** _____

Complete the table below with the information from your schedule:

1. Number of hours of class/day
2. Type of activity (e.g. sitting, on feet all day)
3. Specify for clinical days type of clinical setting and expectations

Monday	Tuesday	Wednesday	Thursday	Friday

A health care provider must complete the following information prior to returning to class or clinical.

_____ Student Name _____ is medically cleared to return to class/clinical with no restrictions.

OR

_____Student Name_____is medically cleared to return to class/clinical with the following restrictions: (Please list restrictions).

OR

_____Student Name_____is **not** medically cleared to return to class/clinical.

Health care provider signature & date: _____
Clinic name and address: _____

A stamp from the clinic is required:

2/2017