

**Practical Nursing Program**  
**Medical Permission to Return**  
**to Classroom/Clinical**



Name: \_\_\_\_\_

**Please complete the table below with the following 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

**Please have your medical doctor complete the following information prior to returning to class or clinical.**

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

\_\_\_\_\_ Student Name \_\_\_\_\_ is medically cleared to return to class/clinical with the following restrictions: (Please list restrictions).

\_\_\_\_\_ Student Name \_\_\_\_\_ is not medically cleared to return to class/clinical.

Signature of MD/NP \_\_\_\_\_

Telephone \_\_\_\_\_