Los Angeles Unified School District

STUDENT HEALTH AND HUMAN SERVICES

ATTACHMENT I

Student Health & Human Services

CONFIDENTIAL

Medical Clearance for Return to School Following Mental Health Intervention Services or Hospitalization

Date:_____

Dear Doctor:

The student named below was either hospitalized or received mental health services recently for being a danger to himself/ herself, danger to others and/or gravely disabled. Medical information from you is essential in planning for the student's safety, educational and health needs.

_____	_____	_____	____
Student Name	Date of Birth	School	Grade

Please complete the following information and return to the parent/guardian to provide to the school upon return to school. Your cooperation is much appreciated.

If the student no longer poses a threat to self and/or others at the time of discharge and can return to school, please sign below and indicate restrictions, if any.

The above named student does not pose a threat to self and/or others at the time of discharge and may return to school:

☐ Without restrictions ☐ With the following modifications/restrictions (indicated below)

Recommended Modifications/Restrictions: _____

Please indicate any prescribed medications and dosages: _____

_____	_____
Doctor's Name	Doctor's Signature
_____	_____
Hospital Name	Contact Number

AUTHORIZATION TO EXCHANGE/RELEASE MEDICAL INFORMATION

TO: _____ RE: _____ _____

Practitioner/Staff Name/Title — Student Last Name — Student First Name

_____ Date of Birth: _____ /_____ /_____

Hospital/Agency/Clinic — Month Day Year

I hereby give you permission to release/exchange the following information:

☐ Medical/Health ☐ Speech & Language ☐ Educational ☐ Psychological/Mental Health ☐ Other – Specify: _____

This authorization shall be valid until _____ unless revoked earlier.

_____	_____
Name of Parent/Legal Guardian	Phone Number
_____	_____
Signature of Parent/Legal Guardian	Date