MESSIAH UNIVERSITY

RETURN FROM MEDICAL LEAVE
UPDATE FROM PROVIDER

To be completed by treating professional:

Name of Student_____ Anticipated Date of Return to School_____

Treating Provider: _____ Credentials: _____

Address: _____

Telephone: _____ Fax: _____

Dates of care: _____ to: _____

What was the initial diagnosis or health problem? _____

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

_____

_____

_____

Please list all current medications, dosages and instructions:

_____

_____

_____

What additional services or support will the student need to manage their health once returned to Messiah? _____

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_____

_____

Will the student follow up with you or other health care providers while at Messiah or when returning home from breaks? If so, when is next follow up appointment? _____

Do you prefer that student follows up with our provider on campus? If so, when would you like follow up and how often? _____

Have you attached corresponding treatment records/labs/reports to allow for appropriate transfer of care or follow up? **Yes/No**

Do you support the decision of this student to return to campus? **Yes/No**

_____ _____

Signature of provider/credentials Date

RETURN COMPLETED FORM TO:

ENGLE CENTER for COUNSELING AND HEALTH SERVICES
Attn: Medical Director
Messiah University
Suite 3028
One University Ave
Mechanicsburg, PA 17055