

## **URGENT CARE DISCHARGE & RETURN TO SCHOOL FORM**

**Date:** [Insert Date]

**Patient Name:** [Insert Patient Name]

**Date of Birth:** [Insert Patient Date of Birth]

To Whom It May Concern,

The above-named patient was evaluated at our Urgent Care facility on [Date of Visit].

**Status:**

The student may return to school on [Date] with no restrictions.

The student may return to school on [Date] with the following restrictions: [Insert Restrictions].

The student must remain home until they are fever-free for 24 hours without medication.

**Medications/Treatments:**

No medication is required during school hours.

The student requires the following medication(s) at school: [Insert Medication Name and Dosage].

**Physician/Provider Name:** [Insert Name/Title]

**Facility Name:** [Insert Urgent Care Name]

**Phone Number:** [Insert Phone Number]

**Signature:** \_\_\_\_\_