Dear Student,

The Student Health Service works in conjunction with the Undergraduate Schools' individual advising offices as well as other offices on campus to evaluate and determine what additional support may be required for a smooth transition to campus. Your home school(s) will manage your return from leave in collaboration with university support services. You should consult with the appropriate advising office(s) about your return process.

College of Arts and Sciences
Wharton School, Undergraduate Division
School of Nursing, Undergraduate
Penn Engineering

Please have your treating physician(s) complete the attached form to assist our office in evaluating your readiness to resume your studies at Penn. These forms will be kept confidential and not released to your school. They will be placed in your medical record within the Student Health Service. There are times when we may need some additional information from your treating physician and we would ask that you give their office permission to speak with us regarding this matter.

Completed information should be sent by mail to my attention or faxed to our office at 215-746-0800. Please do not hesitate to contact our offices directly with any questions or concerns. We can be reached at 215-746-0822.

Respectfully,

Sallyann Bowman, MD
Deputy Director

MEDICAL INFORMATION FORM

The information requested below will aid the Student Health Service in evaluating the named student's request to resume his/her studies. Please attach any additional paper to this form and return it to SHS at the address or fax number below. Thank you.

Return this form to: Sallyann Bowman, MD
Deputy Director, Student Health Service
University of Pennsylvania
3535 Market Street, Suite 100
Philadelphia, PA 19104-3376
Phone: 215-746-0822
Fax: 215-746-0800

To be completed by the student:

Student Name: ____________________

Date of birth: ____________________

Penn ID number: ____________________

I, hereby authorize the Student Health Service to obtain information pertaining to my treatment and care from the person listed below for the purpose of evaluating my application to return from leave. I understand that authorization shall remain valid for one (1) year from the date of my signature below. I have been informed that I may revoke this authorization by written or oral communication at any time.

____________________ ____________________
Signature Date

To be completed by the medical provider.

Name: ____________________ Credentials: ____________________

Address: ____________________

____

Phone: ____________________

Fax: ____________________

1. Clinical diagnosis, including presenting symptoms and results of diagnostic tests

2. Treatment recommendations and status of treatment

3. Date of last visit and student's clinical condition when last seen

4. Is the student in need of ongoing medical care for this problem? If so, please indicate recommendations for continued clinical care.

5. Current medications

6. Recommendations for restrictions, limitations or accommodations of the student's academic or extracurricular activities

7. Additional comments

______________________________ ______________________________
Signature Date

______________________________ ______________________________
Name Telephone

Address ____

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