

MEDICAL RETURN FORM

For Use When Applying for Return to Middlebury Programs, Following a Medical Leave

To the Student:

Please complete your section below on Page 1 of this document and then give this and all attached pages to your treating clinician/health care provider(s).

To the Provider:

The student named below is applying to return to a Middlebury Program following a medical leave. The information you provide will be used to help Middlebury make a determination as to the student's readiness to return. It will not become a part of the student's academic record, but will be retained in the student's medical file. *Please respond to pages 2-3 directly on this form or use your own letterhead if more convenient. Upon completion, please mail or fax this form (Pages 1-3), any additional relevant information, and a copy of your release of information to:*

*Executive Director
Parton Center for Health and Wellness
Centeno House
Middlebury College
Middlebury, VT 05753
Phone 802-443-5141, fax 802-443-3407 (This is a confidential fax machine)*

To Be Completed By The Student

Student Name: _____ DOB: _____

Student ID # _____ Date/Semester you wish to return: _____

Program you are returning to (Undergraduate College, Language Schools, Schools Abroad, etc.):

Authorization to Release Information:

I authorize the clinical staff at Parton Center for Health and Wellness, Middlebury, to exchange information with:

Provider name: _____

Provider address: _____

Provider phone number: _____

This authorization is for the purposes of assisting in the evaluation of my readiness to return to the Middlebury Program listed above, and for the coordination of my care.

I also authorize the clinical staff at Parton Center for Health and Wellness to assess and summarize my medical readiness for readmission to the appropriate Middlebury officials.

Student Signature

Date

To Be Completed By The Clinician/Health Care Provider

Please provide information below that will help the clinical staff at Parton Center for Health and Wellness assess the student's current ability to participate safely and effectively in the academic, residential, and other components of Middlebury Programs.

Clinician Name _____

Address _____

Phone # _____ Fax # _____

Licensed as _____ License # _____ State _____

Date of first encounter _____ Date of most recent encounter _____ Total # of encounters _____

Initial Diagnostic Description _____

Current Diagnostic Description _____

Middlebury Programs are rigorous academic environments. Many students find the course work demanding and, where applicable, the associated language and cultural immersion settings, extremely challenging.

The Programs located in Middlebury, VT (the College and Language Schools), provide short term counseling and medical services for brief, acute illness and injury. We do not provide long-term medical care or counseling, in-patient services, or personal care or monitoring of students in academic, residential or social settings. Specialized treatment providers in our rural area are limited.

Middlebury Programs located outside of Middlebury, VT, do not provide counseling or medical services to students.

In all settings, Middlebury students must be able to live and care for themselves independently, safely and effectively, while fulfilling their academic responsibilities.

Based on your professional assessment and/or treatment of this student, please describe below this student's readiness to return to study at the Middlebury Program, and the extent to which this student is able to participate independently, safely, and effectively in all of the required components of the Program, including but not limited to academic, residential and extracurricular.

What are the current limitations caused by the condition(s) that led to withdrawal? Please be specific:

Please describe your treatment recommendations for ongoing care:

Please describe any accommodations that are necessary to allow the student access to the educational program (please note that some programs require intensive or immersive participation and are unable to make exceptions to those requirements):

Please provide any additional comments or other relevant information that may help us in making a medical return decision:

Clinician's signature: _____

Date: _____