

**St. Johns County School District**  
**Exceptional Student Education**  
40 Orange Street, St. Augustine, FL 32084 (904) 547-7672

**Re-Admittance To School**

Student: \_\_\_\_\_ Date: \_\_\_\_\_

School: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_

**To be completed by parent/guardian:**

My child has recently been ill/hospitalized from \_\_\_\_\_ to \_\_\_\_\_ dates  
and was under the professional care and treatment of the following physician(s)

\_\_\_\_\_ at: \_\_\_\_\_  
\_\_\_\_\_ facility/hospital

**To be completed by physician(s):**

As of today's date \_\_\_\_\_, I have treated the above named student for the  
following condition(s): \_\_\_\_\_

Yes     No    This student is now free of communicable disease and/or is  
in stable condition to attend school on a full time basis.

The student will require the following while at school: \_\_\_\_\_

(please indicate specific instructions)

Medications: \_\_\_\_\_

Special procedures/treatments: \_\_\_\_\_

Precautions/limitations re: physical activity, positioning, feeding, etc.: \_\_\_\_\_

Other student-specific information: \_\_\_\_\_

Physician's signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed name of physician: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_