



Treating Provider's Re-enrollment Questionnaire for Return from a Medical Leave of Absence

Name of Student /Date of Birth

Today's Date

C#

Semester to Return

Initial presenting concerns:

Dates of Treatment: From _____ to _____

Diagnosis: _____

Please describe nature of treatment:

Medication(s) and dates:

Date of last contact with student: _____ Current clinical status: _____

Future treatment plans (specify community referrals, if appropriate):

Prognosis: _____

Ability to function academically (e.g. can student carry a full course load?), independently and in a Residence Hall environment:

Any treatment required while at college, if so, please specify: Yes/No

Name of Treating Provider, Degree

Signature/Date

Street Address

Telephone Number

City _____ State _____ Zip _____

Fax Number _____