GOUCHER | college

Readiness to Return Form

This form is required when a student wants to return to Goucher College after a hospitalization, an official medical withdrawal, medical leave of absence, or reinstatement with a Dean of Students' hold. The form must be completed by the student and the student's healthcare provider. The provider primarily responsible for treating the issue that led to the student's hospitalization or medical leave must complete the form. "Healthcare Provider" means Licensed Healthcare Provider (e.g., MD, DO, Psychologist, Licensed Clinical Social Worker, etc.)

Student Instructions (Sections 1 & 2)

1. Complete Section 1 of this form – an incomplete form will be returned to you for completion without review.
2. Sign the form in Section 2.
3. Deliver this form to your Healthcare Provider at least six weeks before your planned return to the College.

Section 1: Student Information (please print)

Name: _____
Last First Pronouns Goucher ID

Mailing Address: _____
Street City State Zip Code

Phone: _____ Email address: _____

I am completing this form due to (choose one): ◯ Hospitalization ◯ Medical Withdrawal ◯ Medical Leave of Absence

Section 2: Student Statement and signature:

I certify that the information provided above is true and correct.

Student's signature: _____ Date: _____

Healthcare Provider Instructions (Sections 3, 4, 5, & 6)

Healthcare provider must provide this form directly to the address below. It will not be accepted from the student.

1. Complete Sections 3 and 4 for **RETURN TO CAMPUS AFTER HOSPITALIZATION**
2. Complete Sections 3, 4, and 5 for **RETURN TO CAMPUS AFTER MEDICAL WITHDRAWAL**
3. Sign the form in Section 6 – an unsigned form will not be accepted.
4. Return this form directly to the address below via mail, fax, or email within four weeks of the student's planned return to the College.

Important Note: All questions on this form are limited in scope to the conditions, diagnoses, and symptoms that necessitated the student's current hospitalization and medical leave and/or affect the student's qualifications to return to academic and residential life at Goucher College.

Section 3: Licensed Healthcare Provider Information (please print)

Name: _____

License and State: _____ Email address: _____

Licensed as: _____ Clinic/Hospital Name: _____

Mailing Address: _____
Street City State Zip Code

Phone: _____ Fax: _____

Return form: Office of Vice President & Dean of Students
Dorsey 203, 1021 Dulaney Valley Road
Baltimore, MD 21204
Email: care@goucher.edu
Fax: 410-337-6494

Section 4: Licensed Healthcare Provider Report (please print)

In your professional judgment, can the student manage a full course load (12 or more credits, nine credits for a graduate student)?

◯ YES ◯ NO ◯ UNSURE

Please elaborate on your answer: _____

_____

What are your recommendations for continued treatment? _____

_____

_____

Current Medications: _____

Will the student have a Healthcare provider in place in the Towson, Maryland area? ◯ YES ◯ NO

If yes, please identify the provider: _____

If no, who will provide treatment? _____

If no, please explain: _____

_____

Please provide details of the established plan in the event of worsening symptoms or crisis: _____

_____

_____

Will the student have these recommendations in place by the time of potential return to campus? ◯ YES ◯ NO

Please use the space provided if you would like to expand on your responses to the questions, record any other comments or observations you may want to make regarding the student and their ability to function safely and successfully as a student at Goucher College, or include an attachment on letterhead: _____

_____

_____

_____

Section 5: Licensed Healthcare Provider Report: Return to Campus AFTER MEDICAL WITHDRAWAL

Please let us know what actions you've taken:

Prior to completing this form, I spoke with the medical provider, who recommended that the student take medical leave.

Prior to completing this form, I reviewed the Medical Leave Recommendation form filled out by the student's provider at the time of withdrawal or communicated with them directly.

Date of first treatment contact: _____ Date of most recent treatment contact: _____

Frequency of Meetings: _____

Return form: Office of Vice P resident & Dean of Students
Dorsey 203, 1021 Dulaney Valley Road
Baltimore, MD 21204
Email: care@goucher.edu
Fax: 410-337-6494

Diagnosis of Student (i.e., description) _____

_____

Has the medical condition that warranted the initial medical withdrawal been sufficiently managed? ◯ YES ◯ NO

Please provide your professional judgment in response to the following questions regarding the above student.

Has there been a substantial improvement of the student's original medical/psychological condition? ◯ YES ◯ NO

If yes, please check all the following that you have observed a marked reduction of in this student:

Number of Symptoms	Severity of Symptoms	Persistence of Symptoms
Functional Impairment	Subjective Level of Client Distress	

Please provide treatment plan: _____

_____

_____

_____

For how long has the improved condition been maintained?_____

_____

What evidence is demonstrated to suggest that the student has increased ability to manage academic life and live independently in the residence halls? Failure to provide details may result in a delay in the review and decision to return to campus. _____

_____

_____

_____

_____

What responsibilities has the student maintained during their time away from the College that suggests they are ready to return to academic rigors (e.g., employment, volunteerism, etc.) _____

_____

_____

_____

Section 6: Healthcare Provider's Signature

Healthcare Provider's Name / Signature: _____ Date: _____

Return form: Office of Vice P resident & Dean of Students
Dorsey 203, 1021 Dulaney Valley Road
Baltimore, MD 21204
Email: care@goucher.edu
Fax: 410-337-6494

Student Name: _____
Student ID #: _____
Grad. Year: _____
DOB: _____

GOUCHER | college
STUDENT COUNSELING CENTER
1021 Dulaney Valley Road
Towson, MD 21204
P: 410-337-6481
F: 410-337-6005

AUTHORIZATION FOR RELEASE OF CONFIDENTIAL RECORDS AND INFORMATION

I, the undersigned student or legal representative, hereby authorize Student Counseling Center / Office of Vice President & Dean of Students
□ to disclose □ to receive ■ to exchange
the following information from my records in verbal, electronic and/or written form:

- ☐ Psychiatric evaluation from Date:_____
- ☐ Mental Health Records from Date:_____ to Date:_____
- ☐ History and Physical exam performed on Date:_____ Time: _____
- ☐ Lab reports**, x-ray reports, and other test results from Date:_____ to Date:_____
- ☐ Verification of treatment
- ☐ Other:_____

I am aware that the records released may contain information related to sexually transmitted disease, HIV-status, alcohol/drug use, or mental health. I, specifically, PROHIBIT the release of the following information (SPECIFY):

_____INITIAL HERE:_____

Purpose of disclosure of information (check all that apply):

- ☐ At client's request
- ☐ Continuing care
- ☐ Verification of services provided
- ☐ Other:_____

Person/institution to whom information is to be disclosed:

- ☐ Self
- ☐ Goucher College Student Counseling Staff:_____
- ☐ Goucher College Administration/Faculty/Staff: _____
- ☐ Non-Goucher Recipient: _____

Address:_____

Phone/Fax: _____

Expiration Date of Authorization (may not exceed one year): _____

Student Signature _____ Date: _____

Signature of Legal Representative (if applicable):_____ Describe authority to act for the student:_____

You may revoke this authorization at any time, by writing to Director, Goucher College Counseling Center. The revocation will become effective on date received by Director. The recipient of information covered in this release may not make any further disclosure of the information without specific consent of the student or his/her legal representative or as otherwise provided by law.