GOUCHER COLLEGE
REQUEST TO RETURN TO CAMPUS

Student's Name: ____

I. *TO BE COMPLETED BY STUDENT:*

I authorize the release of medical and/or mental health information between ____ (medical or mental health provider) and any of the following Goucher College administrators: Office of the Dean of Students, Office of Student Support and Outreach, Dean On-Call, Director of Student Health Center, Director of the Counseling Center, Student Health Counselor, and/or Director of Residential Life. These administrators may need to disclose the information from the provider, as well as other pertinent information concerning my physical or mental health to the following individuals:

- ☐ Personal therapist: ____________________________________ Phone: __________________
- ☐ Parent/Guardian: _____________________________________ Phone: __________________
- ☐ Other:____ Phone: __________________

Student's signature:____ **Date**: ___________________

II. *TO BE COMPLETED BY MEDICAL/MENTAL HEALTH PROVIDER:*

Provider name and credentials:
Address:
City, State, Zip Code:
Telephone number:
Email address:
Fax Number:

Date of last contact with student or date of assessment:

Diagnoses and/or Diagnostic Impressions:

Current Medications, Dosage, and Relevant Drug History:

Student's Name: ____

Summary of Treatment and Relevant Evaluation(s) (please use another sheet if necessary):

Goucher College is a residential college with a rigorous academic program. In your responses below, please consider the student's ability to participate in their academic program, co-curricular activities, and generally unsupervised community living in the residence halls.

Based on your assessment, is this student emotionally and physically stable and adequately supported to return to a campus environment, rigorous academic responsibilities, and co-curricular activities?
YES _____ NO _____

If you believe that the student is able to return to campus at this time, do you recommend any restrictions on the student's participation in academic, residential, or co-curricular activities?

If you believe that the student is able to return to campus at this time, indicate below any recommendations for, and arrangements with, the student for follow-up treatment. Please note that Goucher's Student Health and Counseling Services provides crisis intervention, brief therapies, and basic medical care. Students returning to campus who require ongoing care are **required** to have a plan in place with a provider in the local area. Student Health Center and/or Counseling Center staff cannot be listed as the primary aftercare provider.

Has the student completed treatment? Yes _____ No _____

Recommendations for continued treatment and/or therapies:

Will you continue to be a provider for this student? Yes _____ No _____
If so, in what capacity? ____

Has the student been referred to another provider in the Towson or Baltimore area? Yes _____ No _____
If so, please provide the following provider information:
Name and Credentials: ____
Address: ____
Phone Number: __________________________________
Fax Number: ______________________________________
Email: ____

Other recommendations or comments related to this student:

Signature: ____ Date: _____________________
State and License Number: ______________________________

Please Return to: Alexandra Graves
Associate Director of Student Support and Outreach
Email: alexandra.graves@goucher.edu
Tel: (410) 769-5088
Fax: (410) 337-6494