Student Readmission: Post-Medical Withdrawal
Health Care Provider Statement

A student seeking readmission following a medical withdrawal must provide to the Student Health Center or Counseling & Psychological Services this form completed by the health care provider(s) who provided treatment during the medical leave. A separate form must be completed by each provider. The provider cannot be a family member, relative, significant other, or family friend of the student; the nature of the provider's relationship must be entirely professional. Please include a signed release of information from the health care provider(s) along with this form permitting consultation with Fairfield University health providers.

A letter providing responses to the information below may be submitted in lieu of completing this form.

Name of student____ Date of Birth________________

Diagnosis____

Treatment modality used____

Indicators of progress since initial medical withdrawal ____

An assessment of the student's ability to manage or cope with the issues which led to the withdrawal:

_____ Competent _____Developing Skill

_____Other____

An assessment of the student's ability to handle a full time college course load and college life (e.g. academic pressure, peer pressure, etc.):

_____Competent

_____Competent, but certain disability accommodations are recommended (student should consult Fairfield University Disability Support Services)

If applicable: List activities/experiences which demonstrate the student's readiness to live independently in the residence halls without supervision: ____

____

An endorsement indicating the student is medically cleared to return to full time college student status:

____Yes, endorsed without reservations

____Yes, endorsed with reservations (health care provider should contact the Student Health Center or Counseling and Psychological Services to discuss further)

(over)

Follow up recommendations and recommended treatment plan:

____Continued treatment is not necessary at this time

____Student will remain in treatment with current provider(s)

____Treatment should be transitioned to Fairfield University provider(s); (provider should contact either the *Student Health Center* or *Counseling and Psychological Services* to discuss)

Signature: ____ Date: _________________

Provider's Name: ____ Professional Credentials: ______________

Address: ____ Telephone Number: ___________________

Additional information may be provided along with this form.

Contact Information:

Student Health Center
Contact: Julia Duffy, Director
Phone: (203) 254-4000, Ext. 2241
Fax: (203) 254-4263

Counseling and Psychological Services
Contact: Susan Birge, Director
Phone: (203) 254-4000, Ext. 2146
Fax: (203) 254-5545

Disability Support Services
Contact: Megan Buxton, Director
Phone: (203) 254-4000, Ext. 2615
Fax: (203) 254-4134