Gettysburg College Health Services
Healthcare Provider Post-Medical Withdrawal
Summary Report and Recommendations

Student Name: ____________________   ________________
Last               First               MI               Date Completed

Treating Healthcare Provider’s Name: ____________________   ________________
Address: ____________________   Telephone: (______) ____________________
                                    ____________________   Fax (______) ____________________

The information requested will assist the Gettysburg College Health Services determine if this student is able to return the academic setting following a medical leave/withdrawal. If a summary letter is preferred, please include all the appropriate information below. This information will be used to assist the student in his/her return to Gettysburg College.

1. Reason student sought your medical intervention.
   __________________________________________________________
   __________________________________________________________

2. Current diagnostic impression(s).
   __________________________________________________________
   __________________________________________________________

3. Date of first visit: ___/___/_____   Date of last visit: ___/___/_____   Date
   Frequency of visits: ____________________   Next appt.: ___/___/_____

4. Surgical/diagnostic procedures and date performed.
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

5. Other treatment modalities and current medication, including dosages.
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

   __________________________________________________________
   __________________________________________________________
Student name: ___________________  ___________________
      Last                                First

7.  Is it your opinion the student’s condition is stable enough to allow return to academic and campus life at Gettysburg College?  ___Yes___ No.  If yes, recommended date of return to campus: ___/___/_____.

8.  If no, comment: _____________________________________________________________

9.  Will you continue to be involved in the treatment of this student upon return to Gettysburg College?  ___yes___ no

10. If student is able to return to campus, what is your recommendations for additional treatment and support for the student upon return to Gettysburg College? (Including how Gettysburg College Health Services, local specialist, or Residence Life officials can assist the student upon return to the campus)
    ___________________________________________________________________________
    ___________________________________________________________________________
    ___________________________________________________________________________

11. Please note other important observations or comments:
    ___________________________________________________________________________
    ___________________________________________________________________________
    ___________________________________________________________________________

If you have any questions or concerns you would like to discuss, please feel free to contact our office.

_____________________________  ___/___/_____
Signature of Healthcare Provider completing form  Date

_____________________________
Print Name

Return form to address below or fax to:  
Gettysburg College Health Service at 717-337-6978

Judith Williams, CRNP  
Director Student Health Services  
Gettysburg College  
300 North Washington St  
Campus Box 436  
Gettysburg, Pa 17325