Readiness to Return and Continuation Plan

Part I – Student Information (Completed by student)	
Student Name:	ID #:
Address:	City/State/Zip Code:
Phone Number:	Email:

Part II – Release of Information (Completed by student)

Authorization for Release of Information

I authorize release of verbal and written/electronic information to and from the medical or mental health professional listed below to the Wheaton College Vice President for Student Development, Dean of Residence Life, Dean of Student Wellness, Associate Dean of Student Wellness, Counseling Center, Learning and Accessibility Services, Student Health Services, and/or Global Programs & Studies regarding (1) the summary of my treatment during my time away from campus, (2) the opinion of the medical or mental health professional regarding my readiness to return to academic studies, (3) obstacles I may face upon returning to academic study, and (4) any recommendations for continuation of treatment. I understand my **Rights and Responsibilities** as stated below and authorize the medical or mental health professional named below to provide **Protected Health Information** (e.g., Psychiatric/Mental Health or Developmental Disabilities; Substance Abuse/Alcohol Treatment; HIV/AIDS Testing or Test Results; Genetic Testing and/or Genetic Counseling), in verbal and/or written form, to the aforementioned Wheaton College offices and officials.

Rights and Responsibilities

Please review and then sign to authorize the disclosure of the information as indicated above.

I understand that I may revoke this authorization at any time. Any such revocation will be valid, except for the release of information that occurred prior to this authorization being revoked. I may inspect and/or copy the information sought to be used or disclosed in this authorization as permitted by applicable law the federal privacy regulations. I understand that by signing this form, I am confirming my authorization that the above-mentioned Wheaton College office(s) and its agents may use and/or disclose my educational and treatment records and information described in this form to the person(s) and/or agency(s) named in this form. I understand that I may request a copy of this authorization after signing below. This authorization is voluntary, and I am under no obligation to sign this form. I understand that refusing to sign this form, however, may negatively impact my ability to be enrolled at Wheaton College for reasons related to personal and community safety. I understand that refusing to sign this form does not stop disclosure of information that is otherwise permitted by law without my specific authorization, consent or permission. I understand that in order to revoke this authorization form, *a written request* must be sent to the Wheaton College office where this authorization form was signed. I understand that revocation of this authorization will not affect any disclosures or actions taken by Wheaton College before receiving the written notice of revocation.

This authorization is good for 12 months from the date of signing. I understand that I may revoke this authorization at any time by contacting student.wellness@wheaton.edu. I understand that revocation of this authorization, however, may negatively impact my ability to be enrolled at Wheaton College for reasons related to personal and community safety.

Student Signature: _____ Date: _____

Part III – Medical or Mental Health Professional Information	
Clinic Name:	Health Provider's Name:
Email:	Phone:
Please check your professional level:	
☐ MD - Psychiatrist	☐ Licensed Therapist (LCPC, LCSW, LMFT)
☐ MD - Primary Care /Internal Medicine	☐ Other (specify):
☐ Licensed Clinical Psychologist	

Part IV – Medical or Mental Health Services Information	
Dates of Service: (REQUIRED FIELD - please list all dates)	Total Hours of Service: (REQUIRED FIELD)
Types of Service Provided (check applicable services provided)	
☐ Individual Therapy	☐ Family Therapy
☐ Psychiatric Service/ Assessment	☐ Medical Evaluation/Physical
☐ Medication Evaluation	☐ Psychological Testing
Verification of Treatment Plan and Professional Judgment of Continuation of Studies (Check all that apply)	
☐ Patient has been complying with prescribed treatment plan	☐ Patient *has not* been complying with prescribed treatment plan
☐ In my professional judgment, patient is able to cope with the rigors of college academic studies while in compliance with his/her treatment plan	☐ In my professional judgment, patient is *not* able to continue with the rigors of academic studies at this time
☐ In my professional judgment, the patient has reasonably arrived at a place where treatment is no longer necessary to be able to continue with the rigors of college academic studies	☐ Other (please specify):

Part V – Continuation of Medical or Mental Health Services
(If a conversation is preferred or warranted, please contact 630-752-5941 to schedule appointment.)

Please provide comments regarding the following:

A) Has this student ever attempted suicide? Y/N When:
How:

B) How concerned are you that this student will struggle with suicidal thoughts and/or behaviors while studying at Wheaton?

(1) Not Concerned; (2) Somewhat Concerned; (3) Very Concerned; (4) Extremely Concerned

Why?

C) Obstacles student may face if student returns to school:

D) Recommendations for continuation of treatment (i.e., frequency of psychotropic medication management and psychotherapy) upon reengaging academic studies and extracurricular activities and other stressful conditions:

E) Recommendations for continuation of treatment upon returning to a demanding social environment within a residential campus community and any present concerns:

I certify by my signature that I provided the services listed herein.

Print Health Professional Name and Title:	
Health Professional Signature:	Date: