PHYSICIAN'S STATEMENT

This is to certify that the person named herein is a patient at the Guam Memorial Hospital and is under my care.

Patient's Name: _____ Admission Date: _____

Patient's condition: ☐ Stable ☐ Critical

_____

_____

_____

Estimated Length of Stay: _____

_____ _____

Date Physician's Name and Signature

Given to Parents/Legal Guardian by (Staff Name & Title) _____

TO PARENTS/LEGAL GUARDIAN: *Present this document to your child's school counselor or teacher. The school counselor/teacher should provide guidance on how your child can maintain with his/her schoolwork, if appropriate. When the counselor provides his/her disposition, return this form to the GMHA Pediatrics Department*

Acknowledged By:

Parent/Legal Guardian Name: _____

Print Full Name

Parent/Legal Guardian Signature: _____ Date/Time: _____

TO THE SCHOOL COUNSELOR/TEACHER: Your student (identified above) is a patient at GMHA. Please provide any guidance to the student and his/her parent or legal guardian on how he/she can maintain the school work that has been missed as a result of his/her admission

SCHOOL COUNSELOR/TEACHER DISPOSITION:

_____

_____

_____

_____

SCHOOL COUNSELOR/TEACHER'S NAME: _____

Print Full Name

COUNSELOR/TEACHER Signature: _____ Date/Time: _____

ACADEMIC EDUCATION FOR LONG-TERM PEDIATRIC PATIENTS

Patient ID

Guam Memorial Hospital Authority
Reviewed/Revised
Form # Stock #