

**PHYSICIAN'S STATEMENT**

This is to certify that the person named herein is a patient at the Guam Memorial Hospital Authority 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: 09/18; Approved: NM (08/18); Social Services (10/18); Education (08/18); Peds (09/18);  
MEC (09/18)

Form # 003