READMISSION TO SCHOOL OF STUDENT
WITH TEMPORARY DISABILITY DUE TO INJURY, ILLNESS OR SURGERY

1. Student Information

Name of Student	❑ M ❑ F Sex	Birth Date	Student Identification Number
Name of School		Grade	Teacher/Room Number

2. Physician or Licensed Health Care Provider Section

PHYSICIAN OR LICENSED HEALTH CARE PROVIDER

The student named above is under my care. It is necessary for him or her to return to school with a temporary disability due to an injury or illness.

❑ Bone fracture ❑ Joint sprain ❑ Muscle strain ❑ Surgery

❑ Seizure ❑ Heat illness ❑ Concussion ❑ Other _____

Precautions/Recommendations/Restrictions due to the injury or illness _____

Duration: _____

a. Permission to be in school:

- ❑ This student has my permission to be in school with:
  - ❑ cast(s) ❑crutches ❑ sling ❑ splint/brace ❑ stitches ❑ elastic bandage(s)
  - ❑ wheelchair ❑ Other (please describe) _____

b. Specific recommendations for recess:

- ❑ This student may participate in recess activities, subject to the above precaution(s).
- ❑ This student **may not** participate in recess activities

c. Specific recommendations for physical education class:

- ❑ This student may participate in physical activities during physical education class, subject to the above precaution(s).
- ❑ This student **may not** participate in physical activities during physical education class.

d. Specific recommendations for extracurricular athletics:

- ❑ This student may participate in physical activities of extracurricular athletics, subject to the above precaution(s).
- ❑ This student **may not** participate in physical activities of extracurricular athletics.

Additional special instructions _____

Stamp physician name/address below:

Signature of Physician		Date
Name of Physician (please print)	License Number	Office telephone

3. Parent or Legal Guardian Section

PARENT OR LEGAL GUARDIAN

Please refer to Recommendations for and Legal References governing the readmission to school with a temporary disability due to injury or illness on the reverse side of this form.

I hereby give consent for a school nurse (or designee) to communicate with my child's Health Care Provider and to counsel school personnel as needed with regard to my child's health. I agree to, and do hereby hold the District and its employees harmless for any and all claims, demands, causes of action, liability or loss of any sort, because of or arising out of acts or omissions with respect to this readmission to school with a temporary disability due to injury, illness or surgery. I agree to comply with district rules related to readmission to school with a temporary disability due to injury, illness or surgery.

I will <u>immediately</u> notify the school if there are any changes in the temporary disability due to injury or illness of my child.

Signature of Parent or Legal Guardian	Date	Home/Mobile Telephone	Work Telephone

Name of Parent or Legal Guardian (please print)

Legal References: California Education Code section 49475

White – School District Canary – Parent or Legal Guardian Pink – Physician or Licensed Health Care Provider

SFA 5110 Rev. 6/18/2014

RECOMMENDATIONS FOR AND LEGAL REFERENCES GOVERNING READMISSION TO SCHOOL WITH A TEMPORARY DISABILITY DUE TO INJURY, ~~OR~~ ILLNESS OR SURGERY

RECOMMENDATIONS

1. Return from Injury or Illness for General Students

a. "General Students" include all students in general except athletes who suffer a concussion or suspected concussion during athletic activity. (see below, Section 2. Concussion Management for Athletes)

b. A student who suffers a significant injury or illness or is suspected to have suffered a significant injury or illness during a school activity should be immediately removed from the activity for the remainder of the day, and should not be permitted to return to the activity until he or she is evaluated by a licensed health care provider.

1) Broken bone(s);
2) Severe joint sprain, requiring a splint or cast;
3) Muscle strain;
4) Seizure;
5) Heat exhaustion and/or heat stroke;
6) Head Injury/Concussion (see below for athletes);

c. The student should not be permitted to return to school and/or the activity until written clearance and release is received from a licensed health care provider with precautions, recommendations, and/or restrictions.

1) Readmission to School of Student with Temporary Disability or Injury form, or
2) Concussion management form (examples):
   a) Acute Concussion Evaluation (ACE) Care Plan (Centers for Disease Control and Prevention),
      (1) http://www.cdc.gov/concussion/headsup/pdf/ace_care_plan_school_version_a.pdf
   b) Return to Learn Plan/Return to Play Plan (Children's Hospital Los Angeles)

d. Licensed Healthcare Provider

1) Medical doctor (MD) or Doctor of Osteopathy (DO)
2) Nurse Practitioner
3) Physician Assistant

2. Concussion Management for Athletes

a. An athlete who is suspected of sustaining a concussion or head injury in an athletic activity shall be immediately removed from the activity for the remainder of the day, and shall not be permitted to return to the activity until he or she is evaluated by a licensed health care provider, trained in the management of concussions, acting within the scope of his or her practice. The athlete shall not be permitted to return to the activity until he or she receives written clearance to return to the activity from that licensed health care provider. (Ed Code, §49475(a)(1))

1) Refer to Section 1.c.2) for example concussion management forms

b. Refer to VCSSFA Best Practices for Concussion Management for more information.

1) http://www.vcssfa.org/RiskControl/BestPractices/tabid/2068/Default.aspx

c. Licensed Health Care Provider for concussions or suspected concussions sustained during extracurricular athletics:

1) The licensed health care provider is to be trained in the management of concussions. (Ed Code, section 49475)
2) For athletes participating in California Interscholastic Federation (CIF) sports, the CIF limits the evaluation to a medical doctor (MD) or doctor of osteopathy (DO). (CIF Bylaw 313)

LEGAL REFERENCES

California Education Code, section 49475.

(a) If a school district, charter school, or private school elects to offer an athletic program, the school district, charter school, or private school shall comply with both of the following:
(1) An athlete who is suspected of sustaining a concussion or head injury in an athletic activity shall be immediately removed from the athletic activity for the remainder of the day, and shall not be permitted to return to the athletic activity until he or she is evaluated by a licensed health care provider who is trained in the management of concussions and is acting within the scope of his or her practice. The athlete shall not be permitted to return to the athletic activity until he or she receives written clearance to return to the athletic activity from that licensed health care provider.
(2) On a yearly basis, a concussion and head injury information sheet shall be signed and returned by the athlete and the athlete's parent or guardian before the athlete initiates practice or competition.
(b) This section does not apply to an athlete engaging in an athletic activity during the regular schoolday or as part of a physical education course required pursuant to subdivision (d) of Section 51220.

READMISIÓN A LA ESCUELA DEL ESTUDIANTE
CON LA INCAPACIDAD TEMPORAL POR LESIONES, ENFERMEDAD O CIRUGÍA

1. Información del Estudiante

Nombre del Estudiante	❑ M ❑ F Sexo	Fecha de Nacimiento	Núm. De Identificación Estudiantil
Nombre del la Escuela		Grado	Maestro/a / No. de Salón de Clase

2. Physician or Licensed Health Care Provider Section

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Additional special instructions _____

Stamp physician name/address below:

Signature of Physician		Date
Name of Physician (please print)	License Number	Office telephone

3. Debe completer esta parte el Padre, la Madre o el Guardián Legal

Por favor, consulte Recomendaciones para y referencias legales que rigen la readmisión a la escuela con una incapacidad temporal debido a una lesión o enfermedad en el reverso de este formulario.

Por este medio otorgo mi consentimiento a que se le comunique a un/una enfermero/a escolar con el médico de mi hijo/a, y a que se le aconseje al personal escolar tocante a la salud de mi hijo como sea necesario.. Consiento en y por este medio dejo a salvo al Distrito y sus empleados de cualquier y todas las reclamaciónes, demandas, causes de acción, responsabilidad o pérdida de cualquier tipo debido o como resultado de actos u omisiones con respeto a readmisión a la escuela con la incapacidad temporal por lesiones, enfermedad o cirugía. Estoy de acuerdo en cumplir con las reglas del distrito relacionadas con readmisión a la escuela con la incapacidad temporal por lesiones, enfermedad o cirugía.

Avisaré a la escuela immediatamente si hay cambios en la incapacidad temporal debido a una lesión o enfermedad que mi hijo/a toma en la escuela.

Firma del Padre o el Guardián Legal	Fecha	Teléfono del Hogar / Celular	Teléfono del Trabajo

Nombre del Padre o el Guardián Legal (en letra de imprenta)

PHYSICIAN OR LICENSED HEALTH CARE PROVIDER

PADRE, MADRE O GUARDIÁN LEGAL

Legal References: California Education Code section 49475

White – School District Canary – Parent or Legal Guardian Pink – Physician or Licensed Health Care Provider

SFA 5110S Approved 06/18/2014

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