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

PHYSICIAN OR LICENSED HEALTH CARE PROVIDER

PARENT OR LEGAL GUARDIAN

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

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

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 immediately 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

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