Los Alamitos Unified School District
HEALTH SERVICES
Medical Release for School Activity

(Purpose: to define the student's ability to participate at school when a health problem appears to be present.)

* Please return completed form to School Health Office. → School FAX #: _____

Name of Student: _____ Today's Date: _____

Date of Birth: _____ Grade: _____ School Name: _____

Health Problem: _____

Parent Name: _____ Emergency Phone: _____

I give permission for school staff to contact the physician for consultations related to this problem as needed.

Parent Signature: _____ Date: _____

Print Physician Name: _____ Phone: _____

FAX: _____

Diagnosis: _____

- Duration of activity restriction/limitation: _____
- Recommendations or limitations for physical activity at school: _____
- _____
- _____

- Conditions that must be reported to the physician: _____
- _____
- _____

X _____ _____

Physician's Signature Date

10/19/10

Office Stamp