long beach unified school district

Office of School Support Service
Coordinated School Services
NURSING SERVICES

READMISSION AFTER INJURY

Dear Parent/Guardian of: _____ Date: 12/19/22
In order for your son/daughter to safely participate in school activities following his/her injury, please have your physician complete the bottom portion of this form and return it to the school nurse when your child returns to school.

Thank you,

, RN School Nurse School

PHYSICIAN'S REPORT TO THE SCHOOL FOLLOWING INJURY

Student's Name: _____ **Birthdate:** _____ **Grade: K**

Date of Injury: _____
Location where injury occurred (check one): ☐ **Off Campus** ☐ **At School**

Type of injury: _____

Type of appliance (check one):
☐ **none** ☐ **brace** ☐ **cast**
☐ **crutches** ☐ **wheelchair** ☐ **sutures**
☐ **other (specify):** _____

Additional instructions/comments: _____
_____

I have examined the above named student and consider him/her able to return to school and participate in regular school activities with the following recommendation(s) (check all that apply):

☐ **Full activity**
☐ **No activity**

☐ **Limited activity, specifically (✓ below)**
- ☐ **No competitive sports**
- ☐ **No running or jumping**
- ☐ **Activity as tolerated**
- ☐ **Other (specify):**

_____

Student may return to full activity on (date):	
Date of next appointment:	
Physician's printed name:	**Address:**
Physician's signature:	**Telephone ( )**
	Date: / /