Tustin Unified School District

HEALTH SERVICES
Medical Clearance and Recommendations for School Participation after Illness or Injury

Medical Practitioner Please Evaluate and Advise

Student Name: _____ DOB: _____ School: _____ Grade _____

Date seen: _____ Diagnosis: _____

☐ Supportive evidence of diagnosis (Medical record, X-ray, Lab, etc.) _____

_____

☐ Student will return to school with: ☐ No Assistive Device ☐ Wheelchair ☐ Cast ☐ Crutches ☐ Walking Boot

☐ Brace ☐ Sutures ☐ Walker ☐ Sling ☐ Elastic ☐ Bandage ☐ Splint

☐ Other Device: _____

Restrictions, if applicable. Please check appropriate item(s):

☐ Student is free of communicable disease and may return to school.

☐ No restrictions- Student may fully participate in all activities, including competitive sports.

☐ Student may participate in all activities, excluding competitive sports.

☐ Student may participate in activities including less strenuous competitive sports (baseball, softball, golf)

☐ Restrictions from Physical Education:

- ☐ No activity during recess
- ☐ No California fitness testing
- ☐ No running or jumping
- ☐ No activities involving body contact
- ☐ No balance/agility activities
- ☐ Lifting Restrictions:
  ☐No lifting ☐ No more than _____ pounds

☐ The following activities are permitted:

- ☐ Activity as tolerated
- ☐ Jog
- ☐ Walk
- ☐ Upper body exercises
- ☐ Lower body exercises
- ☐ Abdominal/core exercises
- ☐ Sports skills (kicking, throwing, etc.)

☐ Other specific restrictions/recommendations: _____

_____

Duration of restriction: _____ ☐ Parent to provide school with updated recommendations after this date

Date student can return to school: _____

Health Care Provider Signature: _____

Printed Name: _____

Phone: _____

Office Stamp must be present

I give permission for the School Nurse to exchange health-related information regarding the above diagnosis with the authorized health care provider.
Doy permiso para que la Enfermera Escolar intercambie información sobre el diagnóstico anterior referente a me hijo/a con el proveedor de salud autorizado.

Parent/Guardian Signature_____ Date_____

Please return this form to the school following the medical evaluation

5/25/21