



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

PHYSICIAN OR LICENSED HEALTH CARE PROVIDER

**1. Student Information**

M  F  
 Name of Student \_\_\_\_\_ 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) \_\_\_\_\_

PARENT OR LEGAL GUARDIAN