Simi Valley Unified School District
Student Support Services 875 E. Cochran St. Simi Valley, CA 93065 805-306-4500

READMISSION AFTER ACCIDENT • INJURY • SURGERY
Requiring Casts, Crutches, Wheelchair, Stitches, Elastic Bandages, or Slings

Students returning to school with casts, crutches, wheelchair, stitches, elastic bandages, or slings as a result of an accident, injury, or surgery must provide a physician's verification of permission to return to school. If a student returns to school without a readmission note please consult your school nurse for a recommendation of whether the student may attend school until a note from the doctor is obtained. A student may not participate in P.E., noontime activities, recess, or be on the playground before or after school until written release by a physician is received.

Part 1: To be completed by the parent or guardian

Student Name _____ Sex_____ Birth Date _____

School _____ Grade _____ Teacher _____

DATE OF INJURY • SURGERY: _____ TYPE OF INJURY • SURGERY: _____

Knowing that the school will assume the usual precautions for the welfare and safety of my child, but realizing that there is always a danger involved with any of the appliances described above when in crowds, I hereby release the school and its personnel from responsibility for any accident which may occur as a result of this temporary disability.

Parent/Guardian _____ Date: _____

Part 2: To be completed by attending physician

Student's Diagnosis: _____

I have examined (student's name) _____ and consider him/her able to participate in regular school activities with the following recommendations:

Permission to be in school with: (Please indicate)

□ Casts □ Crutches □ Wheelchair □ Stitches □ Elastic Bandages □ Slings

Recommendation for recess: (Please indicate)

□ May not participate □ May not participate, but may circulate with peers □ Other

If "Other", please describe: _____

Physical Education: (Please indicate)

□May not participate □May participate with the following limitations: _____

Recommendations in effect until: _____

Physician Name: _____ Signature: _____ Date: _____

Address: _____ Phone: _____