

BURBANK UNIFIED SCHOOL DISTRICT  
Health Services

Roosevelt Elementary School  
Phone: 818-558-4668  
Fax: 818-955-7648

**STUDENT CLEARANCE TO RETURN TO SCHOOL**

(From any hospitalization/medical procedure, including sutures or staples  
or with appliances such as cast, crutches, slings, brace, wraps)

**\*\*\*TO BE COMPLETED BY A LICENSED PHYSICIAN:**

I recommend that \_\_\_\_\_  
Student's name Grade

Return to school on \_\_\_\_\_  
Date

DIAGNOSIS \_\_\_\_\_

Activity restrictions are: \_\_\_\_\_

Appliance: Cast/Boot \_\_\_\_\_ Splint/Brace/Wrap \_\_\_\_\_ Crutches \_\_\_\_\_  
Sling \_\_\_\_\_ Sutures/Staples/Glue \_\_\_\_\_ NOTHING \_\_\_\_\_

Date restricted from: \_\_\_\_\_ through \_\_\_\_\_

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Date / OFFICE STAMP

**\*\*\*TO BE COMPLETED BY PARENT OR GUARDIAN:**

I request permission for my son/daughter \_\_\_\_\_  
to return to school under the conditions described by the physician.

\_\_\_\_\_  
Date \*\*Parent or Guardian's Signature