



SCHOOL PARTICIPATION FOLLOWING AN ACUTE STUDENT INJURY OR ILLNESS

Student Name: _____ Date of Birth: _____ Grade: _____

School: _____ Teacher: _____

Diagnosis: _____ Date of Injury/Illness: _____

The above-named student may return to school on (date): _____

Will the student will return to school with an assistive device? Yes (select all that apply) No

Wheelchair Walker Walking Boot Crutches Scooter

Cast Brace Sling Splint Sutures

Elastic Bandage Other Device: _____

I have examined the above-named student and consider him/her able to participate in regular school activities with the following recommendations:

Recommendations for Recess: May Participate May Not Participate

May Participate with limitations (describe): _____

Recommendations for Physical Education: May Participate May Not Participate

May Participate with limitations (describe): _____

Above recommendations to be in effect until (date): _____

Conditions that must be reported to the physician: _____

Comments/additional instructions: _____

Physician Name (Print Clearly) _____

Physician Signature _____

Physician NPI # _____

Date _____



Medical Office Stamp

To be completed by parent/guardian:

I give my permission for a Cypress School District authorized personnel to exchange health-related information with the authorized health care provider if additional information or clarification is needed. Yes* No

**If "yes" please complete the Authorization for Release and Exchange of Information form*

Parent/Guardian Name (Printed) _____

Signature _____

Date _____