Colton Joint Unified School District

Health Services 909-580-5002 Ext 6191

Joining Together to Go the Extra Mile

MEDICAL RELEASE FOR SCHOOL ACTIVITY

Name of Student: ______________________________ Date of Birth: ______________________________

Address: ______________________________ Phone: ______________________________

Parent Signature: ______________________________ Work Phone: ______________________________

Diagnosis: ____ Duration: ____________________

___ Student can return to school on ____________________
___ Student will need to use a:

___ Wheelchair	___ Cast	___ Sling	___ Brace
___ Crutches	___ Walking Boot	___ Elastic Bandage	___ Splint
___ Walker	___ Able to weight bear on:	___ Unaffected leg	___ Injured leg

___ Other: ____

___ No Assistive Device

I give my permission for my child ______________________________ to return to school under the conditions described on this form. I give permission for the School Nurse to exchange health-related information with the authorized health care provider.

Parent/Guardian Signature ____ Date ______________

Recommendation for physical activity at school:

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Conditions that must be reported to the physician:

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Provider Name (Print): ____________________ Signature: ____________________ Date: ____________

Address: ____ Phone: ____________________

Office Stamp

850 E. Washington, Colton, CA 92324
Commitment to Equal Opportunity

Revised 3/5/26