School Participation Following Injury/Illness

Participación y Seguimiento de la Escuela a la Lesión y/o Enfermedad

Student Name____ **Date of Birth**_______________________
Nombre del Estudiante Feche de Nacimiento

School___________________________________ **Grade**________ **Teacher**___________________________
Nombre de la Escuela Grado Maestro/a

Diagnosis____ **Date of Injury/Illness**________________

The above-named student may return to school on____

Student will return to school with: ◯ No Assistive Device

◯ Wheelchair ◯ Cast ◯ Crutches ◯ Walking Boot ◯ Brace ◯ Sutures ◯ Walker

◯ Sling ◯ Elastic Bandage ◯ Splint ◯ 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 not participate, but may circulate with peers* □ *Other*_____________________________________

Recommendations for Physical Education: □ *May participate* □ *May not participate* □*May participate with limitations (please describe):*
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____
____

Above recommendations to be in effect until (date) ____

Comments/Additional Instructions: ____

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Authorized Health Care Provider Signature ____________________________________

Authorized Health Care Provider Name (print clearly)____________________________

Telephone _______________________________ Date_______________________________

Office Stamp

I give my permission for my child (name)____ to return to school under the conditions described above. I give permission for the School Nurse to exchange health-related information with the authorized health care provider

Doy mi permiso para que mi hijo(a) (nombre)____regrese a la escuela bajo las condiciones descritas anteriormente. Doy permiso para que la Enfermera Escolar/Oficinista de la enfermeria intercambie informacion sobre salud con el proveedor de salud atuorizado.

Parent/Guardian Signature____ Date_________________