

**READMISSION TO SCHOOL OF STUDENT  
WITH TEMPORARY DISABILITY DUE TO INJURY, ILLNESS OR SURGERY**

**1. Student Information**

|                       |   |                           |                                     |
|-----------------------|---|---------------------------|-------------------------------------|
| Name of Student _____ | Sex <input type="checkbox"/> M <input type="checkbox"/> F | Birth Date _____          | Student Identification Number _____ |
| Name of School _____  | Grade _____   | Teacher/Room Number _____ |                                     |

**2. Physician or Licensed Health Care Provider Section**

The student named above is under my care. It is necessary for him or her to return to school with a temporary disability due to an injury or illness.

- |  |                                       |  |                                      |
|--|---------------------------------------|--|--------------------------------------|
| <input type="checkbox"/> Bone fracture | <input type="checkbox"/> Joint sprain | <input type="checkbox"/> Muscle strain | <input type="checkbox"/> Surgery     |
| <input type="checkbox"/> Seizure       | <input type="checkbox"/> Heat illness | <input type="checkbox"/> Concussion    | <input type="checkbox"/> Other _____ |

Precautions/Recommendations/Restrictions due to the injury or illness \_\_\_\_\_

Duration: \_\_\_\_\_

a. Permission to be in school:

- This student has my permission to be in school with:
- |                                      |  |                                |                                       |                                   |   |
|--------------------------------------|--|--------------------------------|---------------------------------------|-----------------------------------|---|
| <input type="checkbox"/> cast(s)     | <input type="checkbox"/> crutches                      | <input type="checkbox"/> sling | <input type="checkbox"/> splint/brace | <input type="checkbox"/> stitches | <input type="checkbox"/> elastic bandage(s) |
| <input type="checkbox"/> wheel chair | <input type="checkbox"/> Other (please describe) _____ |                                |                                       |                                   |   |

**Students in elementary school requiring such medical appliances are not permitted on the playground during recess or allowed to participate in PE Class.**

b. Specific recommendations for recess:

- This student may participate in recess activities, subject to the above precaution(s).  
 This student **may not** participate in recess activities

c. Specific recommendations for physical education class:

- This student may participate in physical activities during physical education class, subject to the above precaution(s).  
 This student **may not** participate in physical activities during physical education class.

d. Specific recommendations for extracurricular athletics:

- This student may participate in physical activities of extracurricular athletics, subject to the above precaution(s).  
 This student **may not** participate in physical activities of extracurricular athletics.

Additional special instructions \_\_\_\_\_

Stamp physician name/address below:

|  |   |
|--|---|
| Signature of Physician _____           | Date _____                                  |
| Name of Physician (please print) _____ | License Number _____ Office telephone _____ |

**3. Parent or Legal Guardian Section**

Please refer to Recommendations for and Legal References governing the readmission to school with a temporary disability due to injury or illness on the reverse side of this form.

I hereby give consent for a school nurse (or designee) to communicate with my child's Health Care Provider and to counsel school personnel as needed with regard to my child's health. I agree to, and do hereby hold the District and its employees harmless for any and all claims, demands, causes of action, liability or loss of any sort, because of or arising out of acts or omissions with respect to this readmission to school with a temporary disability due to injury, illness or surgery. I agree to comply with district rules related to readmission to school with a temporary disability due to injury, illness or surgery.

I will immediately notify the school if there are any changes in the temporary disability due to injury or illness of my child.

|   |            |                             |                      |
|---|------------|-----------------------------|----------------------|
| Signature of Parent or Legal Guardian _____           | Date _____ | Home/Mobile Telephone _____ | Work Telephone _____ |
| Name of Parent or Legal Guardian (please print) _____ |            |                             |                      |

PHYSICIAN OR LICENSED HEALTH CARE PROVIDER

PARENT OR LEGAL GUARDIAN

# RECOMMENDATIONS FOR AND LEGAL REFERENCES GOVERNING READMISSION TO SCHOOL WITH A TEMPORARY DISABILITY DUE TO INJURY, ILLNESS OR SURGERY

## RECOMMENDATIONS

### 1. Return from Injury or Illness for General Students

- a. "General Students" include all students in general except athletes who suffer a concussion or suspected concussion during athletic activity. (see below, Section 2. Concussion Management for Athletes)
- b. A student who suffers a significant injury or illness or is suspected to have suffered a significant injury or illness during a school activity should be immediately removed from the activity for the remainder of the day, and should not be permitted to return to the activity until he or she is evaluated by a licensed health care provider.
  - 1)
  - 2) Broken bone(s);
  - 3) Severe joint sprain, requiring a splint or cast;
  - 4) Muscle strain;
  - 5)
  - 6) Seizure;
  - 7) Heat exhaustion and/or heat stroke;
  - 7) Head Injury/Concussion (see below for athletes);
- c.
- d. The student should not be permitted to return to school and/or the activity until written clearance and release is received from a licensed health care provider with precautions, recommendations, and/or restrictions.
  - 1) Readmission to School of Student with Temporary Disability or Injury form, or
  - 2) Concussion management form (examples):
    - a) Acute Concussion Evaluation (ACE) Care Plan (Centers for Disease Control and Prevention),  
(1) [http://www.cdc.gov/concussion/headsup/pdf/ace\\_care\\_plan\\_school\\_version\\_a.pdf](http://www.cdc.gov/concussion/headsup/pdf/ace_care_plan_school_version_a.pdf)
    - b) Return to Learn Plan/Return to Play Plan (Children's Hospital Los Angeles)
- e. Licensed Healthcare Provider
  - 1) Medical doctor (MD) or Doctor of Osteopathy (DO)
  - 2) Nurse Practitioner
  - 3) Physician Assistant

### 2. Concussion Management for Athletes

- a. An athlete who is suspected of sustaining a concussion or head injury in an athletic activity shall be immediately removed from the activity for the remainder of the day, and shall not be permitted to return to the activity until he or she is evaluated by a licensed health care provider, trained in the management of concussions, acting within the scope of his or her practice. The athlete shall not be permitted to return to the activity until he or she receives written clearance to return to the activity from that licensed health care provider. (Ed Code, §49475(a)(1))
  - 1) Refer to Section 1.c.2) for example concussion management forms
- b. Refer to VCSSFA Best Practices for Concussion Management for more information.
  - 1) <http://www.vcssfa.org/RiskControl/BestPractices/tabid/2068/Default.aspx>
- c. Licensed Health Care Provider for concussions or suspected concussions sustained during extracurricular athletics:
  - 1) The licensed health care provider is to be trained in the management of concussions. (Ed Code, section 49475)
  - 2) For athletes participating in California Interscholastic Federation (CIF) sports, the CIF limits the evaluation to a medical doctor (MD) or doctor of osteopathy (DO). (CIF Bylaw 313)

## LEGAL REFERENCES

### California Education Code, section 49475.

- (a) If a school district, charter school, or private school elects to offer an athletic program, the school district, charter school, or private school shall comply with both of the following:
  - (1) An athlete who is suspected of sustaining a concussion or head injury in an athletic activity shall be immediately removed from the athletic activity for the remainder of the day, and shall not be permitted to return to the athletic activity until he or she is evaluated by a licensed health care provider who is trained in the management of concussions and is acting within the scope of his or her practice. The athlete shall not be permitted to return to the athletic activity until he or she receives written clearance to return to the athletic activity from that licensed health care provider.
  - (2) On a yearly basis, a concussion and head injury information sheet shall be signed and returned by the athlete and the athlete's parent or guardian before the athlete initiates practice or competition.