

# READMISSION TO SCHOOL OF STUDENT WITH TEMPORARY DISABILITY OR INJURY

(i.e., student with a wheelchair, limb cast, crutches, stitches, elastic bandages, or a sling, etc.)

TO BE COMPLETED BY THE LICENSED HEALTH CARE PROVIDER (I.E. DOCTOR) OF STUDENT:

Name of Student: \_\_\_\_\_

Name of Licensed Health Care Provider: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone Number(s): \_\_\_\_\_

Medical License Number: \_\_\_\_\_

Identification of Injury/Disability: \_\_\_\_\_

\_\_\_\_\_

I consider this student able to return to school and participate in regular school activities, subject to the following limitation(s):

\_\_\_\_\_

\_\_\_\_\_

• **Specific recommendations for recess: (Please indicate)**

- This student may participate in recess activities.
- This student may not participate in recess activities.

• **Specific recommendations for physical education class: (Please indicate)**

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

• **Permission to be in school with: (If any, please complete)**

- This student has my permission to be in school with: \_\_\_ casts \_\_\_ crutches \_\_\_ wheel chair \_\_\_ stitches \_\_\_ elastic bandages \_\_\_ slings \_\_\_ other appliance(s) (please describe) \_\_\_\_\_

\_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_

=====

TO BE COMPLETED BY THE PARENT/LEGAL GUARDIAN OF THE STUDENT NAMED ABOVE:

Name of Student: \_\_\_\_\_

Birth date: \_\_\_\_\_ Name of school: \_\_\_\_\_

Parent/Legal Guardian: \_\_\_\_\_

Address of Parent/Legal Guardian: \_\_\_\_\_ Day Telephone: \_\_\_\_\_

I Certify that I have read and understand the information provided above by the Health Care Practitioner (i.e., Doctor) of Student.

PARENT/LEGAL GUARDIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_