



Building a firm foundation through Christ-centered education

Student's Name _____ DOB: ____/____/____

Student's address _____ City _____ State _____ Zip _____

Parent/ Guardian: _____ Contact Number: _____

Grade: _____ Teacher: _____

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):

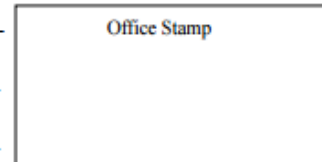
Above recommendations to be in effect until (date) _____

Comments/Additional Instructions: _____

Authorized Health Care Provider Signature _____

Authorized Health Care Provider Name (print clearly) _____

Telephone _____ Date _____



I give permission for my child to return to school under the conditions described above. I give permission to the Health Office Manager to exchange health related information with the Authorized Health Care Provider.

Parent Guardian Signature

Date