Fullerton School District **1401 W. Valencia Drive, Fullerton, CA, 92833**
School Health Services *Phone 714/447-7502 Fax 714/447-7793*

School Participation Following Injury

Participación y Seguimiento de la Escuela a la Lesión

Student Name_____ **Date of Birth**_____

School_____ **Grade**_____ **Teacher**_____

Diagnosis_____ **Date of Injury** _____

The above-named student may return to school on_____

Recommendations to be in effect until (date) _____

Student will return to school with: ○ No Assistive Device

○ Wheelchair ○ Cast ○ Crutches ○ Walking Boot ○ Brace

○ Sutures ○ Walker ○ Sling ○ Elastic Bandage ○ Splint

○ Mobility Scooter ○ Other Device_____

I have examined the above named student and consider the student is able to participate in regular school activities with the folllowing 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)*: _____

Recommendations for Field Trips: ☐ *May participate* ☐ *May not participate* ☐ *May participate with limitations (please describe)*: _____

Comments/Additional Instructions: _____

Authorized Health Care Provider Signature _____

Authorized Health Care Provider Name (print clearly)_____

NPI#: _____

Telephone _____ **Date**_____

Office Stamp

I give my permission for my child (name) _____ to return to school under conditions described above. I give permission for the School Nurse to exchange health-related informatioon with 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 autorizado.*
Parent/Guardian Signature _____ Date_____
Firma del Padre o guardian *Fecha*