IUSD HEALTH SERVICES

RELEASE TO RETURN TO SCHOOL

Stu # | Student's Name | DOB | M/F | School | Grade

Date: ____________________ Completed by: ______________________________

School Nurse | Health Clerk | Office Staff

Dear Parent/Guardian,

Please read and sign the Parent Permission for Physician Release of Information. Have your medical provider complete the bottom portion of this form, and then return the entire form to the school. If you have any questions or need assistance in locating a health care provider, please contact the health office at 949-936- .

, RN

School Nurse | School Address | email

PARENT PERMISSION FOR PHYSICIAN RELEASE OF INFORMATION

As the parent or legal guardian of the above named student, my signature authorizes Irvine Unified School District and the physician(s) identified below to release and exchange medical information relative to the above named student. I certify that I am aware of my right to review any requested records and receive a copy of any materials forwarded.

Parent/Guardian signature: ____ Date: ______________

PHYSICIAN'S REPORT OF EXAMINATION

Results may be faxed to the school at 949-936- .

Diagnosis: ____

Treatment Plan: ____

Student may return to school on: ____________________ ☐ Full time ☐ Modified day of _____ hours/day

Restrictions and duration: ☐ No ☐ Yes Describe: ______________________________

Instructions regarding care of student and use of any equipment at school: ☐ No ☐ Yes Describe: __________

Examiner's Name (please print) | Signature | Date

Address

Phone Number | Fax

Office Stamp

Exclusionary policy is based upon guidelines set forth by the Orange County Health Care Agency and the American Academy of Pediatrics.

Reviewed 07-15-15