IUSD HEALTH SERVICES

RELEASE TO RETURN TO SCHOOL

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

Date: _____ Completed by: _____

☐School Nurse ☐Health Assistant ☐ 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	, Irvine, CA 92	@iusd.org
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: ☐ No ☐ Yes If yes, describe: _____

Restrictions are effective through (date): _____

If the student requires special care or the use of any equipment at school, please describe:

Examiner's Name Date

Address

Phone Number Fax

Office Stamp