VENTURA UNIFIED SCHOOL DISTRICT
Health Programs/Services

READMISSION TO SCHOOL OF STUDENT WITH TEMPORARY DISABILITY OR INJURY

Students returning to school with i.e. a wheelchair, limb casts and splints, or crutches as a result of an accident or injury are to provide a physician's verification. The following outline Part 1 is to be completed by parent/guardian and Part 2 by the attending physician. Thank you for your support to ensure a safe school environment for your son/daughter.

Part 1: To be completed by the parent or guardian

Student Name: ______________________ Sex: ______ Date of Birth: ________________

School: __________________________ Grade: _____ Teacher: __________________

Parent/Guardian Signature: ________________________ **Date:** ________________

Part 2: To be completed by attending physician—*Please complete the following outline including additional information as necessary.*

As the attending physician, I consider this student able to return to school and participate in school activities, subject to the following:

➔ ***Recommendations in effect until:*** *(Specify date)* ______________________________

➔ ***Diagnosis:*** ____

➔ ***Permission to be in school with:***

☐ Wheelchair ☐ Limb casts/splints ☐ Crutches ☐ Other ________________

➔ ***Recommendations for recess:***

- ☐ This student <u>may</u> participate in recess activities.
- ☐ This student <u>may not</u> participate, but may circulate with peers
- ☐ Other: (Please describe) ____

➔ ***Physical education:***

- ☐ This student <u>may</u> participate in physical activities without any limitations.
- ☐ This student may participate in physical education with the following limitations. __________

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- ☐ This student <u>may not</u> participate in physical education activities.

Print Physician's Name: ________________________ Telephone Number: ______________

Physician's Signature: __________________________ Date: ____________________

DISTRITO ESCOLAR UNIFICADO DE VENTURA
Servicios de Salud

READMISIÓN DESPUÉS UN ACCIDENTE O LESIÓN
QUE REQUIERA: YESO, MULETAS, SILLA DE RUEDAS, PUNTOS, VENDAJE ELÁSTICO O CABESTRILLO

El alumno que por motivo de un accidento o lesión regrese a la escuela usando un yeso, muletas, silla de ruedas, puntos, vendaje elástico o cabestrillo, deberá proveer una verificación médica o permiso para regresar a la escuela; y, no podrá participar en Educación física, las actividades del mediodía, el recreo, o estar en el patio de recreo antes o después de clases, hasta que se reciba la exoneración del médico.

Parte 1: El padre o tutor debe llenar esta parte

Nombre del alumno/a__________________________ F/M ________ Fecha de nacimiento ________
Escuela __________________________ Grado ______ Maestro/a ______________
Fecha del accidente__________________________ Tipo de lesión______________________

Firma del padre o tutor______________________ Fecha ______________________

Part 2: To be completed by attending physician

I have examined this student and consider him/her able to participate in regular school activities with the following recommendations.

➔ ***Recommendations in effect until:*** ______________________________
(DATE)

➔ ***Diagnosis:*** ______________________________

➔ ***Permission to be in school with:*** (Please indicate)
☐ casts ☐ crutches ☐ wheelchair ☐ stitches ☐ elastic bandages ☐ slings

➔ ***Recommendations for recess:*** (Please indicate)
☐ May not participate
☐ May not participate, but may circulate with peers
☐ Other: (Please describe) ______________________________

➔ ***Physical education:*** (Please indicate)
☐ May not participate
☐ May participate with limitations, describe ______________________________

Print Physician's Name ______________________ Telephone Number ___________

Physician's Signature______________________ Date ______________________