Fullerton School District **1401 W. Valencia Drive, Fullerton, CA, 92833**

School Health Services *Phone 714/447-7502 Fax 714/447-779*

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 Silla de ruedas ○ Cast Molde ○ Crutches Muletas ○ Walking Boot Arranque de caminar ○ Brace Aaprato ortopédico

○ Sutures Suturas ○ Walker Caminante ○ Sling Esling ○ Elastic Bandage Venda elástica ○ Splint Cabestrillo

○ Mobility Scooter Escuela de Movilidad ○ Other Device_____ Otro dispositivo

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*