Irvine Unified School District
Health Services

PHYSICIAN RELEASE TO RETURN TO SCHOOL

Student Name_____ **Date of Birth**_____

School_____ **ID#** _____ **Grade**_____

Student sent home from school on _____

Current Symptoms: _____

_____

School Nurse/ Health Clerk/Staff signature (circle one) **Date**

(949) 936- **(949) 936-**

School Phone # **School Fax #**

I give permission for my child's healthcare provider to release the information requested below to my child's school.

Parent signature_____ Date_____

PHYSICIAN REPORTED INFORMATION:

Diagnosis: _____

Treatment Plan: _____

_____

_____

Restrictions: _____

_____

Student may RETURN to school on: _____

	_____
Office Stamp/Printed Name of Practice	PHYSICIAN SIGNATURE Date
	_____
	Office Phone # Office Fax #