IUSD HEALTH SERVICES

PHYSICIAN RECOMMENDATIONS FOR PE AND OTHER PHYSICAL ACTIVITIES

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

All public school students participate in physical education activities which are designed to meet their growth and developmental needs. In addition, many students participate in other types of physical activities such as intramural programs or interschool athletics. In order for us to meet your students individual needs, **please have your medical provider complete the bottom portion of this form, and then return the entire form to the school health office.** If you have any questions or need assistance in locating a health care provider, please contact the health office at **949-936- .**

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 all physical activity **without restrictions effective immediately**.

☐ Student should be **excluded from all PE activities** until (date): _____

☐ Student should be **excluded from the activities checked below** until (date): _____

☐ Upper body ☐ Lower body ☐ Core work ☐ Aerobic activity

☐ Other as specified: _____

☐ Student requires use of the following **assistive devices**:

☐ Crutches ☐ Scooter ☐ Wheelchair

☐ Cast ☐ Boot ☐ Brace

☐ Other: _____

☐ Additional recommendations: _____

Examiner's Name | Date

Address

Phone Number | Fax

Office Stamp

Reviewed 07-01-18