



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