Irvine Unified School District
Health Services

PHYSICIAN RELEASE TO RETURN TO SCHOOL

IMPORTANT: RETURN THIS FORM TO NHS ATTENDANCE OFFICE UPON 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: ____

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Restrictions: ____

____

Student may RETURN to school on: ____

____

PHYSICIAN SIGNATURE **Date**

Office Stamp/Printed Name of Practice

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Office Phone # **Office Fax #**