UNLIMITED YOU
ANAHEIM UNION HIGH SCHOOL DISTRICT

School Participation Following Injury/Illness

Participación y Seguimiento de la Escuela a la Lesión y/o Enfermedad

Student Name_____ **Date of Birth**_____
Nombre del Estudiante Feche de Nacimiento

School_____ **Grade**_____ **Teacher**_____
Nombre de la Escuela Grado Maestro/a

Diagnosis_____ **Date of Injury/Illness**_____

The above-named student may return to school on_____

Student will return to school with: ◯ No Assistive Device

◯ Wheelchair ◯ Cast ◯ Crutches ◯ Walking Boot ◯ Brace ◯ Sutures ◯ Walker

◯ Sling ◯ Elastic Bandage ◯ Splint ◯ Other Device_____

I have examined the above named student and consider him/her able to participate in regular school activities with the following recommendations:

Recommendations for Physical Education: □ *May participate* □ *May not participate*
□ *May participate with limitations listed below:*

STUDENT IS PERMITTED TO HAVE MOVEMENT OF: (Indicate right side **R** or left side **L**)

Upper Body: Arm ____ Elbow ____ Wrist ____ Hand ____ Finger____ Head and Neck ____ Trunk ____

Lower Body: Hip _____ Leg _____ Knee ____ Ankle ____ Feet _____ Toe _____

STUDENT MAY PARTICIPATE IN SPECIALLY DESIGNED MODIFIED PE ACTIVITIES SUCH AS:

❑ Stretching ❑ Weight Lifting ❑ Walking ❑ Speed Walking ❑ Catching
❑ Running ❑ Jumping ❑ Twisting ❑ Throwing
❑ Striking ❑ Bouncing ❑ Kicking ❑ Walk/Jogging 1 mile
❑ Modified Games/Sports: Examples _____

Above recommendations to be in effect until (date) ___

Comments/Additional Instructions: _____

Office Stamp

Authorized Health Care Provider Signature _____

Authorized Health Care Provider Name (print clearly)_____

Telephone _____ Date_____

Medical Office Stamp

I give my permission for my child (name)_____ to return to school under the conditions described above. I give permission for the School Nurse to exchange health-related information with the 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 atuorizado.*

Parent/Guardian Signature_____ Date_____