



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 #