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| --- | --- |
|  | IUSD HEALTH SERVICES ILLNESS OR INJURY COMMUNICATION |

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| --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |
| Stu ID | Student’s Name | DOB | M/F | School | Grade |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Date: |  |  | Completed by: |  |
|  | | | | School Nurse  Health Assistant  Office Staff |

|  |  |
| --- | --- |
| **Your child was seen in the Health Office complaining of the following symptoms:** | |
| Red eyes | |
| Rash | |
| Earache | |
| Injury: |  |
| Other: |  |

**If your child is being sent home, he/she/they may return to school when:**

**All symptoms have subsided for a full 24 hours.**

**Your child’s physician has completed, signed, and stamped this form stating when your child is no longer**

**contagious and/or when he/she is well enough to return to school.**

**Have your medical provider complete the bottom portion of this form, if applicable, 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-     .

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| --- | --- | --- |
| , 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 (MD, DO, PA, NP) 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 and duration: | | | No  Yes | | Describe: |  | | | | | |
|  | | | | | | | | | | | |
| Does student require special care and/or use of any equipment at school? | | | | | | | | No  Yes | | Describe: |  |
|  | | | | | | | | | | | |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | | | |  |  |
| Examiner’s Name (please print) | Signature | | Date |  |
|  | | | |  |
| Address | | | |  |
|  | | | |  |
| Phone Number | | Fax | |  | Office Stamp |