

**Woodbridge High School**

Stu ID	Student's Name	DOB	School	Grade

All public school students participate in physical education activities which are designed to meet their growth and developmental needs. In addition, many students participate in other types of physical activities such as intramural programs or interschool athletics. In order for us to meet your students individual needs, **please have your medical provider complete the bottom portion of this form, 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 **949-936-7827**.

<b>Nora Witt, RN</b> School Nurse	<b>2 Meadowbrook Irvine CA 92604</b> School Address	<b>NoraWitt@iusd.org</b> 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 949-936-7809.

Diagnosis: \_\_\_\_\_

Treatment Plan: \_\_\_\_\_

- Student may return to all physical activity **without restrictions effective immediately.**
- Student should be **excluded from all PE activities** until (date): \_\_\_\_\_
- Student should be **excluded from the activities checked below** until (date): \_\_\_\_\_
  - Upper body       Lower body       Core work       Aerobic activity
  - Other as specified: \_\_\_\_\_
- Student requires use of the following **assistive devices:**
  - Crutches       Scooter       Wheelchair
  - Cast       Boot       Brace
  - Other: \_\_\_\_\_

Additional recommendations: \_\_\_\_\_

Examiner's Name	Date
Address	
Phone Number	Fax

**Office Stamp**