CAPISTRANO UNIFIED SCHOOL DISTRICT

San Juan Capistrano, CA

PHYSICIAN CLEARANCE TO RETURN TO SCHOOL

_____/_____/_____/_____

Student's Last Name First Middle Birth Date

_____Home_____Business_____

Student's Address Telephone Telephone

The above named student may return to school on the following date_____.

Concussion ☐ Yes ☐ No

Describe the nature of illness, incapacity, surgery: _____

_____

_____

Activities restrictions if any: _____

_____

_____

_____

Please state the length of time these restrictions are to be observed: _____

_____

_____

Other instructions regarding care/accommodations for the student at the school site: _____

_____

_____

_____ _____

Signature of Physician Date

_____

Printed Name of Physician

_____

Telephone

_____

Address of Physician

MD Stamp (if available)

☐ Copy to athletic office
☐ Copy to health office