# Solana Beach School District:
## School and/or Physical Activity Exemption

Dear Parent(s),

Before your child returns to school from their injury/illness/surgery, please have your physician fill out the information below. This information is important to appropriately support your child's return to school.

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**Name of Student:** _____ **DOB**: _____

**The above named student has recently been treated for:**

**Diagnosis or condition limiting activity:** _____

**Date treated by Physician of injury or illness onset:** _____ **Type of surgery:**_____

_____ Patient is **UNABLE** to attend school beginning _____ /_____ /_____ ending on _____ /_____ /_____

_____ Patient **MAY** return to school on _____ /_____ /_____.
_____ **WITHOUT** restrictions
_____ **WITH** restrictions listed below for _____ days.

**ACTIVITY RESTRICTIONS: (please check all that apply)**

_____ No contact/competitive sports
_____ No running, jumping, kicking
_____ No walking
_____ No physical education classes
_____ No play structure
_____ Student must stay indoors during recess times

**NEEDS/CONSIDERATIONS:**

_____ ALL CASTS: no playgrounds or sandbox activities. Keep cast dry

_____ Patient may use crutches or wheelchair as needed: (indicate appropriate box below)

_____ non weightbearing _____ partial weightbearing _____ weightbearing as tolerated

_____ Medication(s) required during school (additional form required to be completed by physician):

_____

_____ Comments/Other specific limitation (s), please describe: _____

_____

****(IF home school is required because student is physically unable to attend school for an extended period of time, greater than 10 school days due to medical reasons, an additional form will need to be completed by physician).**

- **STUDENT IS RELEASED FOR FULL PARTICIPATION AS OF: _____**

_____ _____ _____
**Healthcare Provider (printed name)** **Physician's Signature** **CA License #**

_____ _____ _____
**Date Signed** **Phone** **Fax #**

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