MARINERS CHRISTIAN SCHOOL *Building a firm foundation through Christ-centered education*

Student's Name _____DOB: ____/____/____

Student's address _____ City_____ State_____ Zip_____

Parent/ Guardian: _____Contact Number:_____

Grade: _____ Teacher:_____

Diagnosis: _____ Date of Injury/Illness: _____

The above-named student may return to school on_____

Student will return to school with: ◯ No Assistive Device

◯ Wheelchair ◯ Cast ◯ Crutches ◯ Walking Boot ◯ Brace ◯ Sutures ◯ Walker

◯ Sling ◯ Elastic Bandage ◯ Splint ◯ Other Device_____

I have examined the above named student and consider him/her able to participate in regular school activities with the following recommendations:

Recommendations for Recess: □ *May participate* □ *May not participate*
□ *May not participate, but may circulate with peers* □ *Other*_____

Recommendations for Physical Education: □ *May participate* □ *May not participate* □*May participate with limitations (please describe):*

_____
_____
_____

Above recommendations to be in effect until (date) _____

Comments/Additional Instructions: _____

_____

Authorized Health Care Provider Signature _____

Authorized Health Care Provider Name (print clearly)_____

Telephone _____ Date_____

Office Stamp

I give permission for my child to return to school under the conditions described above. I give permission to the Health Office Manager to exchange health related information with the Authorized Health Care Provider.

_____
Parent Guardian Signature Date

p: 714.437.1700, ext. 179 | f: 714.437.7976
300 Fischer Ave, Costa Mesa, Ca 92626
Mariners Christian School Health Office | kmatus@marinerscs.org | www.marinerscs.org