SAUGUS
Union School District
Excellence in Elementary Education

24930 Avenue Stanford, Santa Clarita, California 91355
Phone: 661-294-5300 / www.saugususd.org

READMISSION TO SCHOOL AFTER OUTSIDE MEDICAL SERVICES

Student's Name: _____ Date of Birth: _____

School: _____ Grade: _____ Room: _____

ATTENTION PARENT or LEGAL GUARDIAN

Please check the student information on file in school office to make sure all Information is current and correct. Fill out new card if necessary.

PHYSICIAN'S STATEMENT **Date of Injury or Illness:** _____

Type of illness or injury: _____

Diagnosis: _____

Approximate duration of illness: _____

Recommendation regarding student's physical activity while at school:

☐ **Restricted Activity** ☐ **No Restrictions**

Explanation of restricted activity: _____

Is this student required to use a wheelchair, cast, crutch, splint, or other appliance, including dental appliances? Please specify: _____

_____
Physician's Signature

_____
Date

_____
Telephone

Physician's Stamp

_____ _____
Date Signature of Parent/Legal Guardian