LAGUNA BEACH UNIFIED SCHOOL DISTRICT

Laguna Beach, 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_____.

Describe the nature of illness or incapacity: _____

_____

_____

_____

Limitations of activities:_____

_____

_____

_____

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

_____

_____

_____

Other instructions regarding care of the student:_____

_____

_____

_____

_____ _____

Signature of Physician | Date

_____

Printed Name of Physician

_____

Telephone

_____

Address of Physician

MD Stamp (if available)