RETURN TO SCHOOL/PHYSICAL EDUCATION FORM

Student's Name:____

Date:_______________**Diagnosis:**____

RETURN TO SCHOOL STATEMENT

May return to school

May return to school after (#)_________ of weeks

Next appointment:_____________________________

ACTIVITIES RECOMMENDED AT SCHOOL

No restriction of activity

No gym/sports in (#)_________of weeks

May participate in gym, but no competitive sports

May resume sports in (#)_________weeks

May resume gym in (#)__________weeks

May climb stairs with crutches/elevator OK

Needs assistance between classes

Set of extra books for home use recommended

In place of PE, see MODIFIED ACTIVITY

Equipment:

Crutches

Braces

Cast

Walking boot

Other:___________________

# of weeks_______________

MODIFIED ACTIVITY

(check all that apply)

No contact sports

No running/jumping

No weightlifting

No throwing

No upper arm/overhead

RESTRICTIONS:____

COMMENTS:____

PHYSICIAN INFORMATION:

Physician Signature:____

Physician's Name:____

Address:____

Phone Number:____