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 for (#)________ days/weeks
- ☐ May participate in gym, but not in competitive sports
- ☐ May resume sports in (#)_________days/weeks
- ☐ May resume gym in (#)__________day/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 Form**
- ☐ May work with certified athletic trainer
- ☐ Equipment
- ☐ Crutches
- ☐ Braces
- ☐ Cast
- ☐ Walking (CAM) boot
- ☐ Other:_________________________________
- ☐ # of days/weeks________________________

MODIFIED ACTIVITY

(circle all that apply)

- ☐ No contact sports
- ☐ No strenuous sports
- ☐ No overhead sports
- ☐ No running/jumping
- ☐ No weightlifting
- ☐ No throwing
- ☐ No upper arm/overhead
- ☐ Biking/elliptical/stair master OK
- ☐ Swimming OK

☐ RESTRICTIONS:______________________________

☐ ____

☐ ____

☐ COMMENTS:_________________________________

☐ ____

☐ ____

☐ PHYSICIAN INFORMATION

☐ Physician's Signature:___________________________

☐ Physician's Name:______________________________

☐ Address:______________________________________

○ ______________________________________

○ ______________________________________

☐ Phone Number:_________________________________

Revised 7/08