

Patient Name:

Encounter Date & Time: 5/3/2017 10:15 AM

Please see below for this health care provider's directives and information relating to this encounter.

PE Class/Sports/Exercise Status Report

Date onset of condition:

Next Appointment Date:

No PE Class/Sports/Exercise

This patient is placed on no activity from 5/3/2017 through 5/5/2017.

Modified PE Class/Sports/Exercise

This patient is placed on modified activity from 5/6/2017 through 5/13/2017.

This patient's activity is modified as follows:

Not Allowed:

- Contact sports
- Climbing
- Throwing
- Bending

Allowed:

- Noncontact sports

Other needs and/or restrictions:

No PE this week due to back pain/spasm

Modified PE - activities as tolerated next week

MD

This form has been electronically signed and authorized by

(M.D.)

This form contains your private health information that you may choose to release to another party; please review for accuracy.

April 7, 2017

To Whom it May Concern:

Re:
DOB:

This is to certify that the above named patient is under my professional care and

- Was seen in my office today 4/7/2017
- Is unable to return to school/day care today _____
- May return to school/day care on _____
- May return to school/day care with the following restrictions on 4/10/2017

Comments (list restrictions):

- Is able to be excused from physical education, ball sports, contact sports, swimming and water sports, running, jumping, climbing, and any other activity that may re-injure his left arm for a minimum of 10 weeks until 5/26/2017 or otherwise released by the physician named below.
- Must keep cast clean and dry at all times.
- Must be permitted to rest and elevate his left arm as needed for pain management.

Thank You,

A handwritten signature in black ink, appearing to be a stylized name, possibly 'R. [unclear]'. The signature is written over the 'Thank You,' text.

MD