



Chester Community Charter School

ACTIVITY RESTRICTIONS PARENT LETTER

Date _____

Grade _____

Homeroom _____

Student Name _____

Date of Birth _____

The above-named student requires the following activity restrictions due to:

An illness (Diagnosis) _____

An Injury (Diagnosis) _____

Check appropriate boxes below:

Allow student unlimited access to the restroom.

Allow student to carry a water bottle throughout the school day.

Allow student to rest in the health room for 30 minutes for headache.

Allow student to wear sunglasses in school.

Allow student access to elevator throughout the school day.

Allow student extra time between classes.

Restrict from physical activity: Physical education Contact Sports Recess for:

_____ weeks until further medical follow-up on _____
(Date)

Other: Please explain.

Physician Signature: _____ Phone: _____

Physician Stamp: _____ Date: _____

Parent Signature: _____ Date: _____

Nurse Signature: _____ Date: _____