# 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