School Activity Orders Following Illness/Injury/Surgery

Student Name_____ Date of Birth_____

School_____ Grade_____ Teacher_____

Diagnosis_____ Date of Injury/Illness_____

The above-named student may return to school on_____

Student will return to school with:

◯ No Assistive Device ◯ Wheelchair ◯ Cast ◯ Crutches ◯ Walking Boot ◯ Brace

◯ Sutures ◯ Walker ◯ Sling ◯ Elastic Bandage ◯ Splint

◯ Other: Device_____

Is weight bearing allowed on affected limb: ◯ Yes ◯ No

These restrictions remain in place until this date: _____

I have examined the above named student and consider him/her able to participate in regular school activities with the following recommendations:

Recommendations for Recess: □ *May participate* □ *May not participate*
□ *May not participate, but may circulate with peers* □ *Other*_____

Recommendations for Physical Education: □ *May participate* □ *May not participate* □*May participate with limitations (please describe):*

_____
_____
_____

Above recommendations to be in effect until (date) _____

Comments/Additional Instructions:_____
_____
_____
_____

Authorized Health Care Provider Signature _____

Authorized Health Care Provider Name (print clearly)_____

Telephone _____ Date_____

Medical Office Stamp

I give my permission for my child (name)_____ to return to school under the conditions described above. I give permission for the School Nurse to exchange health-related information with the authorized health care provider

Parent/Guardian Signature_____ Date_____

7/29/2024