MEAD SCHOOL DISTRICT

HEALTH SERVICES
2323 E. Farwell Rd • Mead WA 99021 • Telephone (509) 465-6000 • Fax (509) 465-6020

ACTIVITY RESTRICTIONS AT SCHOOL

Student Name:_____ School: _____

Condition/Diagnosis:_____ Grade:_____

Date of Injury:_____ Start date of restrictions:_____ Termination date:_____

Student will use*: ❑ Permanent Restriction

❑ Sling ❑ Cast/Brace ❑ Crutches ❑ Wheelchair ❑ Other _____

*The school does not provide students with equipment such as crutches or wheelchairs.

Specific instructions for equipment needed:_____

_____

Physical Education participation: ❑ Yes *with* restrictions ❑ Full participation ❑ No Participation

Outdoor Recess participation: ❑ Yes *with* restrictions ❑ Full participation ❑ No Participation

*No recess in secondary schools

List any restrictions / specific instructions (such as weight-bearing limit) for activities:_____

_____

_____

LHP Signature: _____ Date:_____
(Licensed Health Professional with Prescriptive Authority)

LHP Name: _____ Phone #:_____
(Print or Stamp)

Parent Signature: _____ Date:_____

❑ Student has related/additional Health Care Plan

For District Nurse Use Only	
Staff Notified (if applicable): ❑ Teachers ❑ PE teacher ❑ Coach ❑ Transportation	
School Nurse Signature	Date