

Blair Academy Center for Health & Well-Being

2 PARK STREET BLAIRSTOWN, NEW JERSEY 07825 | TEL: 908-362-2010 | FAX: 908-362-7885

Orthopedic Consultation 2025-26

Student Name: _____ Date: _____

Diagnosis: _____ Date of Birth: _____

Physician or Licensed Health Care Provider Section

This student's name above is under my care. It is necessary for him or her to return to school on (Date) _____ with temporary disability due to an injury or illness.

Precautions / Recommendations / Restrictions due to injury, surgery, or illness:

_____

_____

Duration: _____ Next Visit Date: _____

Permissions to be in school with:

☐ Splint/brace	☐ Cast
☐ Stitches	☐ Boot
☐ Elastic Bandage(s)	☐ Crutches
☐ Wheelchair	☐ Sling
☐ Other Please Describe	

❑ **How long will the student need to wear or use any of the above listed?**

_____

Specific recommendations for Athletics and Extracurricular Activities

❑ This student may participate in Athletics and extracurricular activities subject to the above precautions

❑ This student may NOT participate in Athletics and /or extracurricular activities

_____

HEALTH CARE PROVIDER NAME

_____

HEALTH CARE PROVIDER SIGN

_____

DATE

OFFICE ADDRESS AND PHONE NUMBER
PRINT OR STAMP



Blair Academy Center for Health & Well-Being

2 PARK STREET BLAIRSTOWN, NEW JERSEY 07825 | TEL: 908-362-2010 | FAX: 908-362-7885

Parent or Legal Guardian: I give consent for the Blair Academy Health Center or designee to communicate with my child's health care provider and to counsel school personnel as needed with regard to my child's health. I agree to and hold the school and its employees harmless for any and all claims, demands, causes of action, liability or loss of any sort because of or arising out of acts or omissions with respect to this readmission to school with a temporary disability due to injury, illness or surgery. I agree to comply with the policy related to readmission to school with a temporary disability due to injury or illness of my child. I agree to immediately notify Blair Academy if there are any changes in the temporary disability due to injury or illness of my child.

_____ _____ _____

Parent/Legal Guardian Signature Parent/Legal Guardian Print Name Date