



Grand Rapids Area Schools

Resilience, Readiness, Excellence

After Injury Activity Restrictions

Date: _____

Diagnosis: _____

To whom it may concern:

Please be advised that _____ was seen in my office on ____/____/____.

Restrictions/limitations (please add end date):

- PE class
- Recess
- Running
- Climbing
- Needs Elevator Use

Special Instructions: _____

Clinic follow up: _____

If you have any questions regarding this patient, please contact our office at: _____

Provider signature: _____