



Medical Excuse Note

Student Name _____ Date of Birth _____

Appointment Date _____ Appointment Time _____

To be completed by Physician:

Select one:

☐ Appointment

☐ Please excuse student from _____ to _____ due to _____

Restrictions

☐ No restrictions (discharge) as of this date: _____

☐ No participation until this date: _____

☐ Modified participation (please specify below) until: _____

Please indicate which activities the student **can** participate in:

☐ Walking

☐ Jogging

☐ Running

☐ Upper body strength training (weight limit: _____)

☐ Upper Body activities

☐ Lower body strength training (weight limit: _____)

☐ Swimming (Middle or High school)

☐ Stationary biking

Specific recommendations and comments: _____

**Attention Care Provider: Few injuries require complete exclusion from all activity.
Most students can participate with modifications.**

Physician Information

Name of Provider _____ Clinic Name _____

Phone Number _____ Fax Number _____

Address _____

Signature of Provider _____ Date _____