RETURN TO SCHOOL/PHYSICAL EDUCATION/SPORT FORM

RETURN TO SCHOOL STATEMENT

☒ May return to school on ____________

☒ Next appointment: ________________

ACTIVITIES RECOMMENDED AT SCHOOL

☒ No restriction of activity

☒ No PE/sports for (#) _________weeks

☒ May participate in gym, but not competitive sports

☒ May resume PE/sports in (#) ______weeks

☒ May climb stairs with crutches

☒ Needs assistance between classes

☒ Needs to pass early

☒ Wear a supportive tennis shoe

☒ May work with certified Athletic Trainer

☒ Equipment:
☒ Crutches
☒ Braces
☒ Cast
☒ Walking (CAM) boot
☒ Other: __________________________

☒ # of weeks _______________________

MODIFIED ACTIVITY

(Check all that apply)

☒ No contact sports

☒ No strenuous sports

☒ No running/jumping

☒ No weightlifting

☒ No upper arm/overhead

☒ Biking/treadmill/elliptical OK

ADDITIONAL RESTRICTIONS:

_______________________________________
_______________________________________
_______________________________________

COMMENTS: ___________________________

_______________________________________
_______________________________________
_______________________________________

PHYSICIAN INFORMATION

Physician’s Signature:
_______________________________________

Physician’s Name:
_______________________________________

Phone: _________________________________

Fax: ___________________________________