



## Health Service Procedure

### Physical Activity Recommendation for Student with Orthopedic Appliance/Equipment

CAST, CRUTCHES, WHEELCHAIR, OR SLING

Students returning to school with a cast, crutches, a wheelchair, or a sling shall have a physician complete this form and return the form to the Health Office.

Student Name: \_\_\_\_\_ D.O.B: \_\_\_\_\_ Grade: \_\_\_\_\_

DATE OF INJURY: \_\_\_\_\_ TYPE OF INJURY/DIAGNOSIS: \_\_\_\_\_

**DURATION** OF RECOMMENDATION BELOW: \_\_\_\_\_

#### Permission to be in school with: (Please check)

Cast     Crutches     Wheelchair     Sling     Other \_\_\_\_\_

#### Recommendations for Recess/Lunch: (Please check)

- May **not** participate in any physical activity
- May **not** participate, but may interact with peers in designated "safe areas" per school policy
- Other: \_\_\_\_\_

#### Physical Education (Please check)

- May **not** participate in Physical Education class until: \_\_\_\_\_  
DATE
- May participate **ONLY** in walking activities until: \_\_\_\_\_  
DATE
- Other: \_\_\_\_\_

PHYSICIAN'S Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name & Address: \_\_\_\_\_

Physician's Office Phone: (\_\_\_\_) \_\_\_\_\_ Fax (\_\_\_\_) \_\_\_\_\_

PARENT/GUARDIAN Signature: \_\_\_\_\_ Date: \_\_\_\_\_