

**MEDICAL RELEASE FOR SCHOOL ACTIVITY**

Name of Student \_\_\_\_\_ Date of Birth \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

Parent Signature \_\_\_\_\_ Work Phone \_\_\_\_\_

Physician Name \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

**Diagnosis:** \_\_\_\_\_

\_\_\_\_ Student can return to school on \_\_\_\_\_

\_\_\_\_ Student will need to use a:

\_\_\_\_ Wheelchair

\_\_\_\_ Crutches

\_\_\_\_ Walker

\_\_\_\_ Other: \_\_\_\_\_

\_\_\_\_ Able to weight bear on: \_\_\_\_ unaffected leg

\_\_\_\_ injured leg

**Recommendation for physical activity at school:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Conditions that must be reported to the physician:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

Office Stamp

\_\_\_\_\_