GRACE LEARNING CENTER

Activity Restriction

Student Name: _____ DOB: _____

School: _____Grade: _____Date: _____

Diagnosis: _____

Restrictions from Physical Education and/or recess in excess of five (5) days require a licensed healthcare provider's written documentation. In addition, students with certain medical conditions will require a licensed healthcare provider's written documentation.

□ May participate in P.E. / sports / recess.

□ May NOT participate in P.E. / sports / recess until: _____

□ May participate in P.E. / sports / recess with the following restrictions (please check all that apply):

□ No running

□ No jumping

□ No swimming

□ No climbing

□ No lifting > ____lbs.

□ Assistive devices needed □ Crutches □ Wheelchair □ Walker □ Sling/Brace _____

□ Indoor activity only when temperature is above _____degrees.

□ No Activity Restrictions through Student's Graduation Year: _____
**unless otherwise informed by the student's current licensed healthcare provider.*

Please list any other restrictions not listed above: _____

_____

These restrictions may change due to changes in his/her status, & you will be notified of any changes.

Licensed Healthcare Provider Name: _____Phone No._____
(print)

_____

Licensed Healthcare Provider Signature Date

I give consent for the exchange of information regarding my child's activity restrictions with the healthcare provider.

Parent/Guardian Signature: _____Phone No._____ Date: _____