RISD RETURN TO SCHOOL
AND ACTIVITY RESTRICTION FORM

To the Health Care Provider: **Date_____**

Student's Name_____ DOB_____

Onset of Illness, Injury, or Surgery (date):_____

Diagnosis/Surgery _____

Student May Return to School on: _____

The student is restricted from: (please check)

___None
___ Physical/Occupational Therapy until _____
___ P.E. until _____
___ Recess until _____
___Contact Sports until _____
___Non-Contact Sports until _____
___Bearing weight until _____
___Walking until _____

___Running until _____

___Lower Body exercise/weights until _____
___Upper Body exercise/weights until _____
___Other_____ until _____

Next follow-up visit with MD (date if any)_____

Student is cleared to return to full activity including contact sports on (date if known)_____

_____ _____
Health Care Provider's Name **Signature**

_____ _____
Date **Phone Number**

Revised 06/04/12