St. Brigid of Kildare
Release to Return to School
or

(Can submit Drs own formatted form with the following information included)

Name- _____ **DOB**: _____
To be completed by Healthcare Provider:

Date Discharged/Office Visit: _____

Student may return to school on _____ with the following restrictions:
_____.

_____May return to all activities without restriction

_____ No physical activities, including physical education and recess until released with a written statement by a Healthcare Provider (Physician/APN/PA).

_____ Total non-weight bearing of the affected extremity

_____ Non-weight bearing except for toe touch with affected extremity for balance

_____ May return to activities with the following restrictions:

NO: ___ jumping ___ climbing ___ running ___ crunches ___ squats ___ contact activities/sports ___ recess. OTHER Restrictions:_____
_____Student is to use crutches and has demonstrated competency

_____ Student is to use _____(specify device; cast, boot,etc) until_____date.

_____ Student may use stairs/steps

Other Limitations or accommodations needed:
_____

Follow up appointment is: _____.

Healthcare Provider Signature: _____ Date: _____
(must have prescriptive authority e.g. MD/DO/APN/PA)