Dear Parents/Guardians: Please have your child's healthcare provider complete this form authorizing his/her return to school.

SURGICAL/MEDICAL CLEARANCE

Date: _____

RE: _____ DOB: _____
(student's name)

The above-named child was seen in my office on _____ for

☐ Surgical procedure on _____ _____
(date) (procedure)

☐ Injury to _____

☐ Other _____

and is authorized to return to school on _____.

The following physical restrictions apply:

☐ Physical Education, Recess, Outdoor Activity

☐ Occupational Therapy

☐ Physical Therapy

Other Modifications or Restrictions: _____

Student my return to full activity on _____.

Physician's Name: _____ Physcian's Stamp:

Physician's Signature: _____