CYO Release to Activities Form

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 affected extremity

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

_____ May return to activities with the following restrictions:

NO: contact activities/sports _____

OTHER: _____

_____ 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: _____

Follow up appointment is: _____.

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