SCHOOL HEALTH SERVICES

Physical Education Waiver or Restrictions

Student Name: ______________________________ Birthdate: ______________

School: ____

Grade/Teacher/Room#: ____

Waiver/Restriction:

_____Waiver Medical Reason: ____________________________________

_____Restrictions Medical Reason: ____________________________________

Restricted Activities:

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Duration/dates of restriction: ____

Additional instructions/precautions: ____

Healthcare Provider name: _____________________________ _____ Phone#: ____________

Healthcare Provider address: ____

Healthcare Provider signature: ___________________________ Date: _________________

Parent/Guardian signature: _____________________________ Date: _________________

Physical Education Teacher: _____________________________ Date: _________________