St. John Regional Catholic School
ACTIVITY RESTRICTION FORM

Student Name: _____ **Grade:**_____ **Date of Birth:** _____

Homeroom Teacher: _____

I. Parent or Health Care Provider:

___The student has a *Temporary Condition* (less than 2 weeks)

A parent may fill out this form for a temporary condition only. Documentation from a health care provider is preferred and may be attached. If the condition extends beyond the 2 week timeframe, please contact the health room.

Injury:_____ Chronic condition:_____

☐**Student may return to activity level as tolerated**
☐**Student may return to activity level on** _____
(date)

II. Health Care Provider only:

____The student has an *Extended Condition*

Injury:_____ Chronic condition:_____

The student has limited:

☐Strength ☐Speed ☐Endurance/cardio ☐Balance ☐Coordination
☐Weight bearing ☐Upper body movement ☐Lower body movement ☐Cognition

Comments:_____

☐**Student requires use of elevator**

Date of re-examination (if applicable):
Outcome: ☐**return to activity level**

☐**Student may return to activity level on** _____**(date)**

Signature: _____

Comments: _____

III. Please check the activities and/or category in which the student CANNOT participate:

MILD	MODERATE		VIGOROUS	
☐calisthenics	☐badminton	☐kickball	☐aerobic exercises	☐running
☐free throw shooting	☐baseball	☐playground activities	☐dance	☐soccer
☐parachute	☐basketball	☐push ups/chin ups	☐flag football	☐steps
☐paddle games	☐bowling	☐softball	☐gymnastics	☐tag games
☐stretching	☐golf	☐throwing/catching	☐jogging	☐tennis
☐walking	☐handball	☐ultimate frisbee	☐jump rope	☐volley ball
	☐jogging	☐whiffle ball	☐lacrosse	

_____ _____ _____
Parent/Guardian Phone Date

_____ _____ _____
Health Care Provider Phone Date

Please return this form to the HEALTH ROOM ***Copies to: Teacher(s), PE, File***