SCHOOL ADMINSTRAVE DISTRICT #54
SKOWHEGAN, MAINE

RETURN TO PARTICIPATION FORM

DATE: _____

Patient Name: _____ DOB: _____

Diagnosis:

_____

_____

Date of Injury/Surgery/Illness: _____

Patient is to remain out of _____School _____Gym _____ Athletic Activities

Until _____

Patient will be able to return to school beginning _____, with the following restrictions:

_____NO Restrictions

_____Restricted School Activities (specify)

_____

_____Restricted Sports Participation (specify)

_____

_____Restricted Gym Activities (specify)

_____

_____Other Restrictions or comments:

_____

_____

I plan to see him/her again on _____

SIGNATURE OF PHYSICIAN **DATE**