Return to School Certificate

Name		**Grade**		**Guardian**	
Address				**Phone**	

☐	**Patient may return to school with no limitations or restrictions from:**
☐	**Patient may return to school on with the below mentioned restrictions & limitations.**

Limits & Restrictions	
Duration of activity per day	
PE limitations and restrictions	
Outdoor exposure restrictions	
Walking duration & restrictions	
Seated activity & restrictions	
Contact with others limitations	
Activities to be specifically avoided	
Others	

Comments & Notes

Student Was Seen by

☐ **Physician** ☐ **Physician's Assistant** ☐ **Nurse Practitioner**

☐ **School Nurse** ☐ **Office Staff** ☐ **Other**

Name & signature		**Address & Contact details**	