RESTRICTED PHYSICAL EDUCATION ORTHOPEDIC CLEARANCE

Date: [Date]

To: [School Name/Physical Education Department]

Student Name: [Student Name]
Date of Birth: [DOB]

DIAGNOSIS / REASON FOR RESTRICTION:
[Insert Diagnosis, e.g., Post-operative ACL repair, Right Ankle Sprain, etc.]

DURATION OF RESTRICTION:
Effective Dates: From [Start Date] to [End Date/Next Evaluation Date]

ACTIVITY STATUS (Please check one):

[ ] **No Physical Activity:** Student may not participate in any PE activities.
[ ] **Restricted Activity:** Student may participate **ONLY** within the limitations listed below.

SPECIFIC LIMITATIONS:

- [ ] No running or jumping
- [ ] No contact sports
- [ ] No weight bearing on [Left/Right] extremity
- [ ] No upper extremity lifting/pushing/pulling
- [ ] Other: [Specify]

ALLOWED ACTIVITIES:

- [ ] Walking only
- [ ] Stretching / Flexibility exercises
- [ ] Lower body only (if upper body injured)
- [ ] Upper body only (if lower body injured)
- [ ] Other: [Specify]

PHYSICIAN INFORMATION:

Physician Name: [Physician Name]
Clinic/Hospital: [Clinic Name]
Phone Number: [Phone Number]

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Physician Signature