HARBORFIELDS CENTRAL SCHOOL DISTRICT

Physician's Note

Student's Name: _____ **Date:** _____

Diagnosis: _____

The above captioned patient is:

_____ unable to return to physical education class until _____

_____ unable to return to athletics (sports) until _____

_____ able to return to physical education class on _____ with the following restrictions _____

_____

_____

_____ able to return to athletics (sports) on _____ with the the following restrictions _____

_____

_____

_____ able to return to physical education without any restrictions

_____ able to return to athletics (sports) without any restrictions

Physician's Name: _____

Physician's Signature: _____

Date: _____

Physician Stamp - Required