Turlock Unified School District

SCHOOL NOTE FOR PHYSICAL EDUCATION

Patient Name: _____ **DOB:** _____

□ Patient was seen by MD on _____

□ Next scheduled clinic appointment _____ at _____

We Recommend:

□ Regular physical education without restrictions

□ Modified physical education until: _____

Check all that apply:

□ No running	□ No sit-ups	□ No pull-ups
□ No jumping	□ No swimming	□ No lifting weights
□ No twisting	□ No contact sports	□ _____
□ No squats	□ No push-ups	□ _____

□ No physical education **at all** until: _____

□ Must wear splint/cast/brace (orthotic) but can otherwise participate

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Physician verification: _____ _____
(Physician's Signature and Printed Name here) (Date)

Physician's address: _____

Please attach business card here:

Attach doctor's business card here