



Queen Creek Unified School District

Activity Restriction

Student Name: _____ DOB: _____

School: _____ Grade: _____ Date: _____

Diagnosis: _____

Restrictions from Physical Education and/or recess in excess of five (5) days require a licensed healthcare provider’s written documentation. In addition, students with certain medical conditions will require a licensed healthcare provider’s written documentation.

- May participate in P.E. / sports / recess.
- May NOT participate in P.E. / sports / recess until: _____
- May participate in P.E. / sports / recess with the following restrictions (please check all that apply):
 - No running
 - No jumping
 - No swimming
 - No climbing
 - No lifting > ____lbs.
- Indoor activity only when temperature is above _____ degrees.
- No Activity Restrictions through Student’s Graduation Year: _____
**unless otherwise informed by the student’s current licensed healthcare provider.*

Please list any other restrictions not listed above: _____

These restrictions may change due to changes in his/her status, and you will be notified of any changes.

Licensed Healthcare Provider Name: _____ Phone No. _____
(print)

Licensed Healthcare Provider Signature Date

I give consent for the exchange of information regarding my child’s activity restrictions.

Parent/Guardian Signature: _____ Phone No. _____ Date: _____