FORT BEND INDEPENDENT SCHOOL DISTRICT
School Health Services

Physical Activity Restrictions

Date: _____

Student's Name: _____

Dear Parent:

You indicated on your child's health history that he/she has a health condition which limits physical activities at school. Please have your physician complete this form and return it to the school nurse so that it may be kept with your child's records.

Thank you for your cooperation,

School Nurse

Health/Medical Condition: _____

Physical restrictions:

_____

_____

_____

Length of time restrictions apply: _____

_____ _____

Physician Signature **Date**

Physician address: **Physician phone:**

_____ _____

_____

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