



Physician's Return to School/Activities/Sports Release Checklist

Kenai Peninsula Borough School District

148 N. Binkley St., Soldotna, AK 99669 (907) 714-8888

This form is required for injuries/illnesses that require more than basic first aid care.

Return this form to your school nurse/school administrator. A list of the student's activities, including physical requirements are listed below. Please complete this form in its entirety and provide the release date for regular return to school/activities/sports and indicate any physical restrictions below, if applicable. The KPBSD Nurse Supervisor will review this release and forward approved return-to-school information to the district approved site-based designee. Students may not return to school/activities/sports until the release has been reviewed and approved by the Nurse Supervisor.

Student Name:	School:	Incident Date:
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Student **is released** to regular school/activities/sports **without restriction** on: _____

Student **is released** to regular school/activities/sports **with restrictions** on: _____

Student **is not released** to any school/activities/sports beginning on: _____

Estimated Date of Next Release:	Date of Next Medical Visit / Evaluation:
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The check boxes below **MUST** be completed by the medical provider.

Daily Activity	No Activity Allowed	Minimal Less Than 1hr / 10 lb. Lifted	Moderate 1-3 hrs. / 25 lbs. Lifted	No Limitation on Activity
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reaching Overhead	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending at Waist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Running	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kicking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Jumping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Computer Use / Entry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grasping Small Objects & Tools	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fine Manipulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Computer Use / Entry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Any Prescriptions, Mental Health Concerns, or Other Limitations: _____

Any durable medical equipment (crutches, wheelchair, walker, etc.) _____

Physician or Other Licensed Health Care Provider Name:	Signature:	Date:
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Physician's Address:	State:	City:	Zip Code:	Phone:
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KPBSD Nurse Supervisor Signature	Date	Approved:	Yes	No
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