MEDICAL CLEARANCE

Required for re-entry to school and to resume therapies & activities

MUST BE COMPLETED BY TREATING PHYSICIAN and faxed back BEFORE the student returns to school.

Fax Numbers: Oakland Campus 201-644-2223 or Fair Lawn Campus 201-791-1504

Student's Name: _____ Date: _____
Reason for absence: _____
The student is not contagious and may return to school on _____/_____/_____

If surgery, please specify procedure: _____

Did the student receive: ___Botox and/or ___Alcohol Blocks
Location of Injections:_____

Is the student cleared to participate in the following **without restrictions** at this time?

Physical Therapy	□ Yes	□ No
Occupational Therapy	□ Yes	□ No
Speech Therapy	□ Yes	□ No
Feeding Therapy	□ Yes	□ No
Adapted PE and yoga	□ Yes	□ No
Standing Program (30-45 min/day)	□ Yes	□ No

If **"NO"** is checked off above, please specify **restrictions:**

- Passive range of motion _____
_____
- Weight Bearing _____
_____
- Positions to Avoid _____
_____
- Precautions (hip, spine, osteoporosis, etc) _____
_____
- Stander/Walker/Bike _____
_____
- ADL/Toileting Concerns _____
_____
- Other _____
_____

If school staff have questions regarding this document, please indicate contact information of medical professional we may contact:
Name:_____
Phone:_____ Fax:_____ Email:_____

Signature of Physician_____ Date: _____
Physician's stamp: