Medical Clearance Form

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

Student's Name: ____ Date __________________________________

The student may return to school on _____/______/_____

Diagnosis: ____

Diagnostic tests and results: (radiology imaging, etc.) ____

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:**

If restrictions, date of follow up appointment:____

Passive range of motion ____

Weight Bearing ____

Positions to Avoid ____

Precautions (hip, spine, osteoporosis, etc.) ____

Stander/Walker/Bike ____

ADL/Toileting Concern ____

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 HCP: ____ Date: ________________________________

Office Stamp: