



# Physician's Release

\_\_\_\_\_ has been under my care.

Individual's Name

**Reason for Visit:** \_\_\_\_\_.

May return to school/ work on \_\_\_\_\_.  
Date

May resume Early Intervention services on \_\_\_\_\_.  
Date

No restrictions

**The following restriction(s) is determined to be medically necessary:**

Physical limitation(s): \_\_\_\_\_ through \_\_\_\_\_  
Date

No running and /or jumping through \_\_\_\_\_  
Date

No lifting of weight over \_\_\_\_\_ pounds through \_\_\_\_\_.  
Date

Leave of absence from job/school responsibilities  
from \_\_\_\_\_ through \_\_\_\_\_  
Date Date

Other \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Attending Physician Signature (**NO STAMPS**)

\_\_\_\_\_  
Date