Stark County Board of Developmental Disabilities

MED 4B

Physician's Release

_____ has been under my care.
Student's Name

Reason for Visit: _____.

☐ May return to school 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 school attendance

from _____ through _____
Date Date

Other_____

_____

_____

Comments: _____

_____

_____

_____ _____
Attending Physician Signature **(NO STAMPS)** Date