Lincoln Middle School

Fitness, Movement, and Sport
Limitation/Restriction Form

(To be completed by attending physician)

Specific functional limitations and/or restrictions

Patient's Name

_____

Check ☑ only those that apply.

Physical:

	Limitation	Restriction
Walking	☐	☐
Running	☐	☐
Lifting	☐	☐
Carrying	☐	☐
Pushing/Pulling	☐	☐
Jumping	☐	☐
Throwing	☐	☐
Bending/Twisting/Turning	☐	☐
Sustained Postures	☐	☐
Gripping	☐	☐
Reaching	☐	☐
Fine Dexterity	☐	☐
Balance	☐	☐
Other (specify):	☐	☐

_____

_____

Definitions:

Limitation: This patient is able to perform the activity in a reduced capacity. For example, the patient is not able to perform in class with the usual speed, strength or number of repetitions, or for the usual duration

Restriction: The patient is advised not to perform in this activity in any capacity.

Mental:

	Limitation	Restriction
Reasoning	☐	☐
Concentration	☐	☐
Memory	☐	☐
Critical decision-making	☐	☐
Alertness	☐	☐
Other (specify):	☐	☐

_____

Environmental:

	Limitation	Restriction
Exposure to heat/cold	☐	☐
Exposure to dust/smoke	☐	☐
Other (specify):	☐	☐

_____

PLEASE RETURN THIS COMPLETED FORM TO YOUR FITNESS, MOVEMENT, AND SPORT TEACHER

Does this patient require medical aids (e.g. splint, brace, crutches) or personal protective equipment (e.g. mask, gloves)?

☐ **Yes** ☐ **No** Please specify:_____

Please provide necessary details about any restrictions or limitations you have identified. _____

_____

_____ _____

(Physician's Signature) (Date)