



ORANGE-ULSTER BOCES HEALTH SERVICES MEDICAL RESTRICTION FORM

Student's Name: _____ DOB: _____ Date: _____

TO: HEALTH CARE PROVIDERS – Please indicate which, of the following applies to this student and the medical reason for any restriction. Thank you.

A) **NO RESTRICTIONS** - *Restrictions required for school activities or physical education.*

-OR-

B) **ADAPTIVE PHYSICAL EDUCATION** - *Student may participate in all school activities that have been adapted to meet the special needs of each student.*

Students who have limitations and/or who are physically challenged routinely have adaptations to their school programs. *Students do not need to be restricted further unless there are additional medical problems.*

-OR-

C) **SEIZURE PROTOCOL ACTIVITY LEVEL**

*(Only for Students Diagnosed With Seizures-please check box)

CATEGORY 1 Student has a history of seizures. Student can participate in all in school activities.

Last seizure activity _____ years.

CATEGORY 2 Student has a history of seizure that requires direct supervision by staff when student is using elevated, rotational equipment or engaged in activities that involve heights or climbing.

OTHER Please describe what limitations the student requires in order to maintain their safety.

-OR-

D) **PHYSICAL EDUCATION RESTRICTION (other than for seizures)**

***Please check the activities the student is not to participate in:**

Contact/Collision	Limited Contact/Impact	Strenuous Non Contact	Non Strenuous Non Contact	Non Strenuous (Individual)
Floor Hockey <input type="checkbox"/>	Basketball <input type="checkbox"/>	Badminton <input type="checkbox"/>	Archery <input type="checkbox"/>	Batting <input type="checkbox"/>
Sleigh Riding <input type="checkbox"/>	XC Skiing <input type="checkbox"/>	Horseback <input type="checkbox"/>	Bowling <input type="checkbox"/>	Crawling <input type="checkbox"/>
Snow Tubing <input type="checkbox"/>	Softball <input type="checkbox"/>	Shop <input type="checkbox"/>	Golf <input type="checkbox"/>	Hop/Jump <input type="checkbox"/>
Soccer <input type="checkbox"/>	Volleyball <input type="checkbox"/>	Swimming <input type="checkbox"/>	Ping Pong <input type="checkbox"/>	Kicking <input type="checkbox"/>
Touch Football <input type="checkbox"/>	ABLE w/Rope Climbing* <input type="checkbox"/>	Track <input type="checkbox"/>	Shuffle Board <input type="checkbox"/>	Skipping <input type="checkbox"/>
	ABLE -no rope climbing <input type="checkbox"/>		Walking <input type="checkbox"/>	Throwing <input type="checkbox"/>

ABLE is an adventure bases learning experience involving a classic ropes course of climbing. Students wear full harness, helmet and have adults spotting them.

Restricted Until: _____ Diagnosis: _____

Telephone No: _____ Address: _____

Signature X _____ Print Name _____ Date _____

Form must be completed & signed by Physician, Nurse Practitioner, or Physicians Assistant licensed to practice in NYS

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