Office of School Support Services
STUDENT HEALTH SERVICES

PHYSICIAN'S RECOMMENDATION FOR PHYSICAL EDUCATION CLASS ACTIVITIES

Student's Name _____ Birthdate _____ Grade _____

Dear Physician,

Students participate in physical education classes, including Adapted PE classes for students who meet state and district eligibility requirements. These classes involve a variety of activities and utilize numerous physical skills. In order to insure the student's safety and well-being, it is important that teachers and other school staff be aware of any restrictions and/or contraindications involving this student.

DIAGNOSIS/MEDICAL CONDITION: _____

Can this student participate in general physical education class activities without any restrictions?
☐ YES ☐ NO

If NO, please mark all the activities and skills in which the student **MAY** participate:

☐ Locomotor activities (walking, running, skipping, hopping, jumping, climbing stairs, etc.)
☐ Ball skills (throwing, catching, rolling, kicking, striking, etc.)
☐ Agility (running and turning quickly, maneuvering under, over and around objects, etc.)
☐ Balance (static/stationary, dynamic/moving)
☐ Calisthenics-type exercises (sit-ups/curl-ups, stretching, leg lifts, arm circles, etc.)
☐ Cardio-respiratory/cardiovascular fitness (endurance running/walking, cycling, rowing, etc.)
☐ Swimming (high school only)
☐ Sports and games (involving combinations of above)
☐ Games and activities that may involve physical contact (basketball, soccer, flag football, etc.)
☐ Other (list) _____

List any specific restrictions, contraindications or special instructions including protective equipment or devices:
_____

ANTICIPATED DATE STUDENT MAY RETURN TO FULL ACTIVITY: _____

_____ _____
Physician's **printed** name Address (must include FACILITY STAMP)

_____ _____ _____
Physician's **signature** Telephone Date

PARENTS: Please read and sign: I have discussed the above condition and restrictions with my child's physician. I also authorize, as needed the sharing of information related to my child's health between the school nurse and the physician.

_____ _____
Parent signature Date

Please return this completed form to the school nurse as soon as possible. Thank you.

_____ _____ _____
School Nurse School Telephone