Menlo Park City School District

Student Services Department

181 Encinal Avenue, Atherton, CA 94027
(650) 321-7140 x5911 Fax: (650) 292-2200
School Nurse

Original to Health File.
Teacher please distribute as follows:
Cc: Teacher, PE teacher

PHYSICAL EDUCATION MODIFICATION

Date _____ Check Site: ☐Heritage Oak ☐Laurel ☐Encinal ☐Oak Knoll ☐Hillview

Student: _____ DOB _____

Teacher: _____ Grade _____

Please bring this form to your child's doctor or clinic if s/he has a health condition that limits or prevents participation in PE class at school. *Favor de llevar este forma a su clinica o medico si su nino/a no puede participar en su clase de educación fisicoo o si tiene limitaciónes.*

Problem/*problema* _____

_____

School Nurse/*enfermera* or other designated staff/*el otro personal señalado* _____

Parent/*padre o madre*: I give permission for health care provider – school to exchange health information for school academic planning. *Le doy permiso a la clinica o al medico para cambiar su información con la escuela.*

Parent Signature/*firma*: _____ **Date/*fecha*** _____

Physician's Recommendation for Modified Activity

The PE teachers seek the advice and cooperation of physicians and parents to provide a beneficial education program for all students. Please complete this form to help us establish an activity program specifically designed our student under your care. Mail or FAX the completed form to the school.

Date of Exam: _____ Physician's Name _____ Phone _____

Diagnosis or description of the condition _____

_____

Length of time in modified activity _____ Is student able to dress for PE? _____

Please check the acceptable group of activities:

☐ Fairly vigorous activities at 75% with NO PHYSICAL CONTACT INVOLVED.
☐ Moderate activities which DO NOT INVOLVE RUNNING.
☐ Severely restricted which involves NO PHYSICAL ACTIVITIES.
☐ Other. If an exercise or physical therapy program has been provided for this student, please attach a copy.

_____

_____

Date s/he may resume normal activities _____ with/without (circle one) brace or joint support.

☐ If permanent modifications are required, please specify here. _____

_____

Physician's Signature _____ **Phone** _____ **Fax** _____

Physician's Printed Name _____