

CONEWAGO VALLEY SCHOOL DISTRICT

130 Berlin Road · New Oxford, PA 17350 · (717) 624-2157 · Fax (717) 624-5020

To the Parent/Guardian of _____, Date: _____

Pupils registered in Pennsylvania schools are required by school law to attend courses of instruction in physical education. In addition to the regular physical education classes, the Conewago Valley School District has an individual adaptive program. This program is designed for students who (on the recommendation of their physician) need modified activity, rehabilitation, or therapy, and are not permitted by same physician to participate in the regular physical education class.

Please complete the information requested below and return it to the nurses' office as soon as possible. Your signature on the form below will enable your child to be included in this valuable program. Your signature also gives permission to us to contact your physician about your child's condition if any questions arise and allows the physician to give any recommendations that he or she may have for correcting the condition(s). You then need to have your physician complete pages two and three and return it to the school either through the mail or by fax.

The additional two sheets should be taken to your health care provider as soon as possible.

Sincerely,

School Nurse

.....
(Do Not Detach)

I would like my child, _____, grade _____ to participate in the Adaptive Physical Education Program in the Conewago Valley School District.

Physician Name

Physician's Phone #

Physician's Address

Parent or Guardian Signature

Date

PHYSICAN RECOMMENDATION

****PHYSICIAN, PLEASE RETURN THIS FORM TO THE SCHOOL HEALTH SERVICE SUPERVISOR****

**Conewago Valley School District
130 Berlin Road
New Oxford, PA 17350
Attn: Dr. Karen Slpe, Ed. D.
Fax: 717-624-5020
Phone: 717-624-2157 x 1007**

Date: _____

Dr. _____: (Please Print)

_____ : (Phone Number)

My patient, _____, is to be enrolled in Adaptive Physical Education.

The Conewago Valley School District has an adaptive physical education program, which provides activities that meet the needs of the student regardless of the disability or injury that he or she has. A parent's permission form has been provided authorizing the release of any necessary information. Please complete the appropriate forms and return them to the health stuie. Thank you for your cooperation in this matter.

Sincerely,

Physician's Signature

ADAPTIVE PHYSICAL EDUCATION PROGRAM
PHYSICIAN'S ORDERS

Student/Patient _____ D.O.B. _____

Date _____

On _____ (date), I examined _____ and

Recommend that he or she participate in the activities which are checked below for:

_____ weeks

_____ months

Physician's Signature

The above-mentioned patient has the following condition(s):

Physican, please indicate below, which activities are acceptable for the student to participate.

___ Aerobic Activities (Jump Rope and Step
___ Archery

___ Badminton Skills
Bowling (4lb. Ball)
Basketball (Games)
___ Boccie Ball (Lawn bowling with a light
Weight ball

___ Calisthenics (stretching)
___ Corrective Exercises (Please Specify)
___ CPR
___ Croquet
___ Exercise Bike Riding
___ Eye Hand Activities

___ Field Hockey
___ First Aid
___ Folk Dancing (Square Dance, Country
Dance)

Football (Flag or Touch)
Golf
Gymnastics/Tumbling
Horseshoes
Jogging
Orienteering (Compass Reading)

___ Paddle Ball
___ Physical Fitness Testing
 ___ 50 Yard Dash
 ___ 400 Meter Run

___ Pull-ups
___ Shuffle Board
___ Shuttle Run
___ Sit/Curl Ups

___ Shuttle Run
___ Soccer (Dribbling & Passing)
___ Soccer (Games)
___ Softball Throw
___ Standing Broad Jump
___ Table Tennis
 ___ Throwing Events
___ Volleyball (with a balloon)
___ Walking

Weight Lifting
 ___ Free Weights (2, 6, 10 lbs.)
 ___ A variable resistance machine
 ___ Other (Please explain below)

