



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