PATERSON PUBLIC SCHOOL

ACTIVITY LIMITATION FORM

PS#: _____ **(973) 321-** _____ **DATE GIVEN:** _____ **DATE RETURNED:** _____

STUDENT: _____ **DOB:** _____ **GRADE/HR:** _____

Dear Doctor:
Our records indicate that the above named student requires an individual activity plan. Please provide a diagnosis and what accommodations, if any, are needed. Will you kindly check below the activities that the student may participate in?

PROGRAM OF FULL PARTICIPATION: _____ YES _____ NO

Relating *to* ***DIAGNOSIS*****:** _____

Student **MAY PARTICIPATE FULLY** in the school program **WITHOUT RESTRICTIONS**.

PHYSICIAN PRINT/ STAMP: _____ **PHONE:** _____

PHYSICIAN SIGNATURE: _____

OR:

PROGRAM OF RESTRICTED ACTIVITY:

Start date: _____ **End Date:** _____

Relating to **DIAGNOSISI:** _____, *the following plan is indicated.*

Student **MAY PARTICIPATE** in the following activities:	**YES**	**NO**
WARM-UP EXERCISES: Stretching , walking		
LOW IMPACT AEROBICS*:* Jumping, hopping, jogging, dance, Tae Bo		
SWIMMING:		
STUNTS: Tumbling, rolling, balance, strength		
PHYSICAL FITNESS TESTING: Running, sit-ups, push-ups, pull-ups		
NON-CONTACT GAMES: Paddle ball, jump rope, badminton, tennis, bowling, other racket sports		
WEIGHT TRAINING PROGRAM: Free weights, treadmill		
TRACK AND FIELD: Sprints, intermediate & distance running, long jump, high jump, shot-put		
APPARATUS: Climbing, vaulting, support, suspension		
COMPETATTIVE GAMES: Soccer, hockey, basketball, baseball, softball, whiffleball, volleyball, speedball, touch football		
RECESS PLAY:		

STAIR CLIMBING (Circle) : **YES** **NO** * Number of flights of stairs allowed per day _____

USE OF HELMET in gym: **YES** **NO** in recess: **YES** **NO** in class: **YES** **NO**

OTHER PROTECTIVE *and/***or ASSISTIVE DEVICES** ***(please specify):*** _____

OTHER RESTRICTIONS: _____

PHYSICIAN PRINT /STAMP _____ **PHONE:** _____

PHYSICIAN SIGNATURE _____ **DATE:** _____

_____ INITIAL EXAM _____ ANNUAL FOLLOW UP

Approved by School Physician: _____ **Date:** _____