Manteca Unified School District
Department of Health Services

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Medical Provider Recommendation for Physical Activity at School
Mobility Assistive Devices – Physician Order

Student Name: _____ Diagnosis: _____

Date of Birth: _____ School Site: _____

MEDICAL PROVIDER RECOMMENDATION FOR PHYSICAL ACITIVITY AT SCHOOL:

Due to the above health diagnosis, the school requires a medical recommendation for physical activity. Please complete the form based on the student's current medical condition. This form is good for up to one school year. If you have any questions regarding this form, you can call Health Services at (209) 858-0782.

_____ No restrictions.

_____ Modified physical activity. Please **CHECK** the activities below in which this child is **able** to participate in:

_____ Running	_____ Running the mile	_____ Jumping	_____ Climbing
_____ Baseball	_____ Football	_____ Golf	_____ Gymnastics
_____ Wrestling	_____ Soccer	_____ Bending	_____ Stooping
_____ Crawling	_____ Weightlifting	_____ Volleyball	_____ Swimming
_____ Water Polo	_____ Basketball	_____ Fitness Testing	_____ Jog/Walk
_____ Kickball	_____ Tetherball	_____Calisthenics	_____ Badminton
_____ Body Conditioning		Other _____	

_____ Child may participate in physical activity, including physical education; however, the child may select his or her own comfort level of involvement. The child will determine the need to rest or discontinuation of the activity on an as needed basis.

_____ No PE or physical activities recommended until cleared by physician listed below. (New form needed to remove restrictions).

_____ Environmental temperature or hydration concerns (please list): _____

_____ Duration of recommendations: _____

MOBILITY ASSISTIVE DEVICE: PHYSICAN ORDER FOR CURRENT ACADEMIC SCHOOL YEAR

1. Student needs: Crutches _____ Wheelchair _____ Walker _____ Motorized scooter _____ Other assistive device: _____
2. Reason/Diagnosis: _____
3. Physician initials indicate student has been shown how to use assistive device safely (this includes steps, stairs, door transitions, etc.)
   _____ Initials of ordering physician.

Additional comments: _____

_____

Signatures: (Provider Stamp may be used in addition to signature for name, address, phone number in the space below.)

Medical Provide Name: _____ Phone Number: _____

Medical Provider Signature: _____ **Date:** _____

Parent/Guardian Signature: _____ **Date:** _____

School Nurse Signature: _____ **Date:** _____

Principal Administrator Signature: _____ **Date:** _____

Provider Stamp (optional)