PHYSICAL ACTIVITY MODIFICATION FORM School Year: _____

TO: Medical Provider for _____ DOB: _____
Student's Name

From: _____ School

All pupils attending schools in California are required to attend classes of instruction in physical education. These classes are required to be adapted to meet individual pupil needs. This means that a pupil who is unable to participate in the entire physical education class should have his/her activities modified to meet and/or improve his/her condition.

We have learned that there may be a need for restricting physical activity for the above named student. In order to better understand the student's needs in the school setting, please provide us with the following information.

1. Diagnosis: _____
2. May the student participate in all Physical Education Class activities and in competitive sports, intramural and interscholastic? _____ Yes _____ No

3. **If activity is limited, please check what he/she may do.**

CONTACT/ COLLISION	**LIMITED CONTACT/IMPACT**	**STRENUOUS NON-CONTACT**	**NON-STRENUOUS NON-CONTACT**
( ) FOOTBALL	( ) BASEBALL	( ) RUNNING	( ) WALKING
( ) SOCCER	( ) BASKETBALL	( ) CROSS COUNTRY	( ) GOLF
( ) FIELD HOCKEY	( ) DODGEBALL	( ) TRACK & FIELD	( ) PADDLE TENNIS
( ) WRESTLING	( ) SOFTBALL	( ) DANCE (SWING)	( ) BOWLING
( ) FLOOR HOCKEY	( ) VOLLEYBALL	( ) TENNIS	( ) BADMINTON
( ) LACROSSE	( ) WEIGHT ROOM	( ) AEROBICS	( ) WARMUP STRETCH
	( ) FOOTBALL Touch/flag		
	( ) BASKET-FOOTBALL		
	( ) ROPE CLIMBING		
	( ) SKIING		
	( ) DIVING		
	( ) HANDBALL		

4. Duration of restriction (Please indicate time frame): _____
5. Other Comments: _____

_____ _____
Health Care Provider (Print Name) Signature

Phone #: _____ Date: _____

4/16