



William Floyd Union Free School District

of the MASTICS – MORICHES – SHIRLEY

Our rich history builds a promising future!

Kevin M. Coster
Superintendent of Schools

Tina Stone, BSN, RN
Lead Nurse
(631) 874-1546

STUDENT: _____

GRADE: _____

Dear Healthcare Provider,

Your patient, _____, is registered in this school district and has indicated an inability to participate fully in sports and/or the regular physical education program. So that you may assist us in designing a program adapted to meet his/her individual needs, would you kindly complete this form and return it to his/her school nurse. Thank you for your cooperation.

Check only where **NO PARTICIPATION** is recommended:

CONTACT/COLLISION (STRENUOUS) LIMITED CONTACT (STRENUOUS)

<input type="checkbox"/> FIELD HOCKEY	<input type="checkbox"/> BASEBALL	<input type="checkbox"/> FOOTBALL	<input type="checkbox"/> BASKETBALL
<input type="checkbox"/> LACROSSE	<input type="checkbox"/> GYMNASTICS	<input type="checkbox"/> SOCCER	<input type="checkbox"/> SOFTBALL
<input type="checkbox"/> WRESTLING	<input type="checkbox"/> VOLLEYBALL	<input type="checkbox"/> CHEERLEADING	

NON-CONTACT (STRENUOUS) NON-CONTACT (NON-STRENUOUS)

<input type="checkbox"/> CROSS COUNTRY	<input type="checkbox"/> BOWLING	<input type="checkbox"/> TRACK AND FIELD	<input type="checkbox"/> GOLF
<input type="checkbox"/> SWIMMING	<input type="checkbox"/> FRISBEE	<input type="checkbox"/> WEIGHT TRAINING	<input type="checkbox"/> STRETCHING
<input type="checkbox"/> WALKING	<input type="checkbox"/> PROJECT ADVENTURE	<input type="checkbox"/> YOGA	<input type="checkbox"/> PILATES

**** STUDENT MAY SELF-LIMIT PHYSICAL EDUCATION ACTIVITIES AS TOLERATED ****

**** EXCLUDED FROM PHYSICAL EDUCATION COMPLETELY ****

DIAGNOSIS: _____
This is to certify that I have examined the above patient and recommend that his/her physical education program be modified as specified above until _____ (date).

PHYSICIAN'S SIGNATURE (WITH STAMP) DATE

NOTE: A copy of this report will be attached to the student's health record with duplicates sent to the physical education teacher and/or coach.
126B-RV23

John S. Hobart Elementary School
Nurse - 874-1248 / 874-1910 (Fax)

Moriches Elementary School
Nurse - 874-1402 / 874-1948 (Fax)

Nathaniel Woodhull Elementary School
Nurse - 874-1303 / 874-1599 (Fax)

Tangier Smith Elementary School
Nurse - 874-1345 / 874-1374 (Fax)

William Floyd Elementary School
Nurse - 874-1270 / 874-1884 (Fax)

William Floyd Learning Center
Nurse - 874-1914 / 874-1594 (Fax)

William Floyd Middle School
Nurse - 874-5555 / 874-5558 (Fax)

William Floyd High School
East Nurse A-Le - 874-1139 / 874-1209 (Fax)
West Nurse Li-Z - 874-1259 / 874-1548 (Fax)

William Paca Middle School
Nurse - 874-1418 / 874-1411 (Fax)

Su hijo(a)_____ está registrado en el distrito escolar y el historial médico obtenido, requiere información detallada del plan de cuidado indicado por el médico. Dicha información nos ayudará a diseñar un programa adaptado a satisfacer las necesidades del estudiante. Favor consultar con el médico de su hijo (a) y solicitarle completar este cuestionario para retornarlo a la enfermera de la escuela. Gracias por su cooperación.