



SAN MATEO UNION HIGH SCHOOL DISTRICT

PHYSICAL EDUCATION MEDICAL EXEMPT FORM

School name: _____

School address: _____

PART 1: TO BE COMPLETED BY THE PARENT/GUARDIAN	
Student Name:	Date:
Address:	Home Phone:
School:	DOB:
Physician's Name:	Phone:
I give my permission to the SMUHSD to confidentially and discreetly use the content of this form to plan my student's Physical Education Program.	
Parent/Guardian Signature: OR Electronic Signature:	Date:

PART 2: TO BE COMPLETED BY THE PHYSICIAN	
Medical diagnosis:	
Duration of the condition is: <ul style="list-style-type: none"> • Short Term • Long Term • Permanent 	The condition is: <ul style="list-style-type: none"> • Progressive • Non-progressive
Date student may return to unrestricted activity:	Date student will be reexamined:
Functional capacity: <ul style="list-style-type: none"> • Unrestricted (no restriction on contact or intensity) • Mild restriction (only avoid vigorous activities) • Moderate restriction (limits sustained, strenuous activities) • Severe restriction (limits are severe) 	

PART 3: TO BE COMPLETED BY THE PHYSICIAN

Check all activities that you consider to be appropriate for the student to participate in. Remember all activities will be modified for student's ability level.

- Step Aerobics
- Power walk (4 min laps)
- Running (jogging/sprinting)
- Swimming
- Curl Ups
- Free Weights (light)
- Pull Ups
- Weight Machines
- Push Ups
- Individual sports/games
- Team sports/games
- Tumbling

Additional recommendations for modification?

Signature of Authorized Health Care Provider:

Electronic Signature:

OR

Date: _____

Health Care Provider Address Stamp (required):

This form is to be turned in to the school Health Office.