



Physical Activity Physician's Recommendations

Student: _____ Date: _____

Date of Birth: _____ School: _____

PE Teacher: _____ Grade: _____

DURATION:

The student's physical activities will be limited for the following period of time: _____.

PERMISSION TO BE IN SCHOOL WITH: Cast Crutches Wheelchair Sling Other

RECOMMENDATION FOR RECESS/LUNCH/PHYSICAL EDUCATION PROGRAM:

- May participate in all activities and Physical Education Program **WITHOUT RESTRICTIONS.**
- MAY NOT PARTICIPATE** in any physical activity or Physical Education Program during the dates listed above.
The student may be assigned a "Safe Area" per school policy during recess/lunch or physical education class.
- May participate in **LIMITED PHYSICAL EDUCATION ACTIVITIES.**

By checking a box below provides authorization for the student to participate in the physical activity.

NOTE: School District Practice does NOT allow a student with a cast/ orthopedic appliance to actively participate in the Physical Education Program with the exception of a walking class.

<input type="checkbox"/> Walking	<input type="checkbox"/> Jogging	<input type="checkbox"/> Swimming
<input type="checkbox"/> Dance	<input type="checkbox"/> Jumping /Plyometrics / Walking Stairs	<input type="checkbox"/> Weight Lifting <input type="checkbox"/> Upper Body Only <input type="checkbox"/> Lower Body Only
<input type="checkbox"/> Flexibility/Stretching/ Yoga	<input type="checkbox"/> Running	<input type="checkbox"/> Other

Additional Recommendations/Restrictions:

Physician's Signature _____ Phone Number _____ Date _____

Parent's Signature _____ Phone Number _____ Date _____

TVUSD USE ONLY			
IMPEP REQUEST BY:			
SIGNATURE		DATE	
<input type="checkbox"/> P.E. TEACHER	<input type="checkbox"/> NURSE	<input type="checkbox"/> COUNSELOR	<input type="checkbox"/> IMPEP REQUESTED