Roseville Joint Union High School District

Include Picture Here

REQUEST FOR MODIFIED OR ADAPTED PHYSICAL ACTIVITY

Parent Signature_____ Date: _____

TO BE COMPLETED BY PHYSICIAN

Recommendations for modified or adapted physical education activity:

Student/Patient's Name_____

Probable Term of Disability_____

DIAGNOSIS: Please indicate the type and extent of disability and make recommendations pertaining to each type (neurological disorder, heart/lung condition, orthopedic condition, postural deviations, hearing problems, vision problems, other problems).

_____

_____

Please indicate body areas in which exercise should be limited or eliminated: _____

_____

Please provide activity recommendations for student's participation in a high school physical education class. **Please provide attached note if necessary.**

Movements	Omit	Moderate	Unlimited	Remarks
Flexion/Extension				
Hanging				
Lifting				
Pulling				
Pushing				
Running				
Stretching				
Swimming				
Throwing				
Twisting				
Walking				
Other				

Physician's Name (please print)_____Date: _____

Physician's Signature_____ Phone: _____

Address: _____