CLEVELAND HEIGHTS HIGH SCHOOL PHYSICAL EDUCATION PROGRAM MEDICAL FORM

Print Name
Student _____ DOB ____/_____/____ ID# _____ Teacher _____ Class Period _____

I authorize the below listed physician or their staff to release any and all information to Cleveland Heights High School to develop the most appropriate Physical Education Program for my child.
Guardian
Signature _____ Date ____/_____/____ Work Phone _____ Home Phone _____

TO THE PHYSICIAN: The Americans with Disabilities Act (ADA), Section 504 of the Rehabilitation Act, and the Individuals with Disabilities Education Act (IDEA) require that every student, regardless of ability, is offered "physical education." In order to help make modifications for the student's physical education program, please check the activities below which **<u>are appropriate</u>** for this student based on the following:

DIAGNOSIS: _____

Notice regarding Asthma: Preventative medicine enables most students with exercise-induced asthma to participate in sports programs. The physical education department encourages students with asthma to participate actively in sports but also recognizes and respects their limits based on the following:

Please check all activities or exercises listed below in which the student **CAN PARTICIPATE** based on the above diagnosis:

____ **No Restrictions**

Mild		**Moderate**		**Vigorous**	
____ Basic Movement	____ Swim Aerobics	____ Aerobics	____ Swimming	____ Advanced Swimming	____ Hard Running
____ Full Body Calisthenics	____ Upper Torso	____ Badminton	____ Table Tennis	____ Basketball	____ Touch Football
____ Light Swimming	____ Walking	____ Frisbee	____ Tennis	____ Body Building	____ Track & Field
____ Lower Torso		____ Golf	____ Volleyball	____ Floor Hockey	____ Weight Lifting
		____ Jogging	____ Weight Lifting		
		____ Softball	____ Yoga		

Specific Corrective exercises or activities (prescribed by physician) _____
_____
_____

Signature Of Physician _____ Printed Name of Physician _____ Date _____

Address _____ Fax No. _____ Phone No. _____

PLEASE RETURN COMPLETED FORM TO YOUR BUILDING NURSE