



# FREMONT UNION HIGH SCHOOL DISTRICT

Cupertino High School | Fremont High School | Homestead High School | Lynbrook High School | Monta Vista High School | Adult School

## RECOMMENDATIONS/ACCOMMODATIONS FOR PHYSICAL ACTIVITY IN SCHOOL

Student Name: \_\_\_\_\_ DOB: \_\_\_\_\_ School Year: \_\_\_\_\_

Date of Most Recent Evaluation: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD 10 Code: \_\_\_\_\_

Diagnosis Date: \_\_\_\_\_ Treatment Plan: \_\_\_\_\_

Current Medications: \_\_\_\_\_

### The following **recommendations** are guidelines for physical activity in school (SELECT ONE):

\_\_\_\_\_ (1) May participate in the entire physical education program without restriction including all varsity competitive sports.

\_\_\_\_\_ (2) May participate in the entire physical education program except for varsity competitive sports where there is strenuous training and prolonged physical exertion (e.g. football, hockey, wrestling, lacrosse, soccer, basketball). Less strenuous sports such as baseball and golf are acceptable at the varsity level. *All activities are acceptable during the regular physical education program.*

\_\_\_\_\_ (3) May participate in the physical education program except for restriction from all varsity sports and from excessively stressful activities such as rope climbing, weight lifting, sustained running (i.e. laps) and fitness testing. Must be allowed to rest when tired.

\_\_\_\_\_ (4) May participate only in mild physical education activities such as circle games, golf, and badminton.

\_\_\_\_\_ (5) May participate in walking activities.

\_\_\_\_\_ (6) Restricted from the entire physical education program. Please provide reason: \_\_\_\_\_

Recommended accommodations: \_\_\_\_\_

THESE MODIFICATIONS EXPIRE ON \_\_/\_\_/\_\_.

THE STUDENT WILL BE REEVALUATED FOR REVISION OF THESE RECOMMENDATIONS ON \_\_/\_\_/\_\_.

**Please note: Modifications will expire on the modification expiration date, the student's next re-evaluation date, or at the end of the current semester – whichever occurs first.**

\_\_\_\_\_  
Healthcare Provider Name

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Fax