

Physical Education/Recess Modifications

Student Name: _____

Birthdate: _____

TO BE COMPLETED BY AN AUTHORIZED HEALTHCARE PROVIDER

(California licensed physicians, surgeons, dentists, optometrists, podiatrists, nurse practitioners, nurse midwives, and physician assistants - California Code of Regulations, Title 5, section 601[a])

Diagnosis: _____

Recommendations for School:

☐ May return to PE/Recess with no restrictions

☐ May Not return to PE/Recess until _____

☐ May participate in PE/Recess with the following restriction/modifications

☐ May Not participate in School Athletics until _____

☐ Additional Comments

Healthcare Provider Name/Signature _____

Telephone _____

License # _____

Date _____

Nursing & Health Services May 2025