

# PATERSON PUBLIC SCHOOL

## ACTIVITY LIMITATION FORM

PS#: \_\_\_\_\_ (973) 321- \_\_\_\_\_ DATE GIVEN: \_\_\_\_\_ DATE RETURNED: \_\_\_\_\_

STUDENT: \_\_\_\_\_ DOB: \_\_\_\_\_ GRADE/HR: \_\_\_\_\_

Dear Doctor:

Our records indicate that the above named student requires an individual activity plan. Please provide a diagnosis and what accommodations, if any, are needed. Will you kindly check below the activities that the student may participate in?

**PROGRAM OF FULL PARTICIPATION:** \_\_\_\_\_ YES \_\_\_\_\_ NO

Relating to **DIAGNOSIS:** \_\_\_\_\_

Student **MAY PARTICIPATE FULLY** in the school program **WITHOUT RESTRICTIONS**.

PHYSICIAN PRINT/ STAMP: \_\_\_\_\_ PHONE: \_\_\_\_\_

PHYSICIAN SIGNATURE: \_\_\_\_\_

OR:

**PROGRAM OF RESTRICTED ACTIVITY:** Start date: \_\_\_\_\_ End Date: \_\_\_\_\_

Relating to **DIAGNOSIS:** \_\_\_\_\_, the following plan is indicated.

Student **MAY PARTICIPATE** in the following activities:

|   | YES | NO |
|---|-----|----|
| <b>WARM-UP EXERCISES:</b> stretching , walking  |     |    |
| <b>LOW IMPACT AEROBICS:</b> Jumping, hopping, jogging, dance, Zumba   |     |    |
| <b>SWIMMING:</b>  |     |    |
| <b>STUNTS:</b> Tumbling, rolling, balance, strength   |     |    |
| <b>PHYSICAL FITNESS TESTING:</b> Running, sit-ups, push-ups, pull-ups   |     |    |
| <b>NON-CONTACT GAMES:</b> Paddle ball, jump rope, badminton, tennis, bowling, other racket sports               |     |    |
| <b>WEIGHT TRAINING PROGRAM:</b> Free weights, treadmill   |     |    |
| <b>TRACK AND FIELD:</b> Sprints, intermediate & distance running, long jump, high jump, shot-put                |     |    |
| <b>APPARATUS:</b> Climbing, vaulting, support, suspension   |     |    |
| <b>COMPETITIVE GAMES:</b> Soccer, hockey, basketball, baseball, softball, volleyball, speedball, touch football |     |    |
| <b>RECESS PLAY:</b>   |     |    |

**STAIR CLIMBING (Circle) :** YES NO \* Number of flights of stairs allowed per day \_\_\_\_\_

**USE OF HELMET** in gym: YES NO in recess: YES NO in class: YES NO

**OTHER PROTECTIVE and/or ASSISTIVE DEVICES (please specify):** \_\_\_\_\_

**OTHER RESTRICTIONS:** \_\_\_\_\_

PHYSICIAN PRINT /STAMP \_\_\_\_\_ PHONE: \_\_\_\_\_

PHYSICIAN SIGNATURE \_\_\_\_\_ DATE: \_\_\_\_\_

\_\_\_\_\_ INITIAL EXAM \_\_\_\_\_ ANNUAL FOLLOW UP

Approved by School Physician: \_\_\_\_\_ Date: \_\_\_\_\_