



LIVERMORE
SCHOOL DISTRICT

Livermore Valley Joint Unified School District

685 East Jack London Boulevard, Livermore, CA 94551

Tel (925) 606-3200 Fax (925) 606-3329

Request for Physical Education Restrictions/Limitations

Student Name: _____ Date of Birth: _____

School: _____

Physician's Authorization (This form is valid only through July 31st of the current school year.)

Student's Diagnosis: _____

Estimated duration of limitation: From _____ To: _____ Follow up date: _____

☒ Regular physical education program, or activity level with no modifications required.

☒ Due to my patient's condition, I have prescribed complete rest and inactivity during physical education class and any extracurricular sports/physical activities until the date of _____.

☒ I have indicated the activities my patient can/can not participate in below:

Yes	No	
		Badminton
		Frisbee/Running Games
		Flag Football
		Basketball
		Running (fast pace)
		Jogging (moderate pace)
		Walking (brisk pace)
		Walking (regular pace)
		Dodgeball
		Pickle Ball
		Lacrosse
		Floor Hockey
		Track & Field Events
		Soccer/soccer type games
		Softball
		Volleyball
		Weight Lifting - upper body
		Weight Lifting - lower body
		Yoga
		Pilates

Yes	No	Calisthenics
		Sit Ups
		Push Ups
		Jumping Jacks
		Long & Vertical Jumps

Yes	No	Swimming
		Swimming Laps
		Walking in the pool
		Water Polo/Water Games

Yes	No	Aerobic/Other
		Circuit Training
		Medicine balls (4 - 20lbs)
		Jumping rope
		Resistance bands
		Bosu balls (side step/balance)
		Agility activities
		Stretching activities

Physicians Signature: _____ Date: _____
Physician Name printed: _____
Provider (Kaiser, Blue Cross, etc): _____
Address, city, zip: _____
Phone: _____

Healthcare Provider's Stamp

Parent/Guardian Consent

I hereby request that the school assist with the activity restrictions mentioned above for my student. I give my consent for the school nurse or other designated school personnel to contact the health care provider to exchange information regarding the above orders. I will submit additional documentation from my student's health care provider when needed.

Signature of Parent/Guardian

Date