



ORANGE-ULSTER BOCES HEALTH SERVICES MEDICAL RESTRICTION FORM **2026-2027**

Student's Name: _____ **DOB:** _____ **Date:** _____

TO: HEALTH CARE PROVIDERS – Please indicate which, of the following applies to this student and the medical reason for any restriction. Thank you.

A) **NO RESTRICTIONS - Restrictions required for school activities or physical education.**
 -OR-

B) **ADAPTIVE PHYSICAL EDUCATION - Student may participate in all school activities that have been adapted to meet the special needs of each student.**

Students who have limitations and/or who are physically challenged routinely have adaptations to their school programs. Students do not need to be restricted further **unless there are additional medical problems.**

-OR-

C) **SEIZURE PROTOCOL ACTIVITY LEVEL**

*(Only for Students Diagnosed With Seizures-please check box)

- ☐ **CATEGORY 1 Student has a history of seizures. Student can participate in all in school activities. Last seizure activity _____ years.**
- ☐ **CATEGORY 2 Student has a history of seizure that requires direct supervision by staff when student is using elevated, rotational equipment or engaged in activities that involve heights or climbing.**
- ☐ **OTHER Please describe what limitations the student requires in order to maintain their safety.**
- _____

-OR-

D) **PHYSICAL EDUCATION RESTRICTION (other than for seizures)**

***Please check the activities the student is not to participate in:**

Contact/Collision	Limited Contact/Impact	Strenuous Non Contact	Non Strenuous Non Contact	Non Strenuous (Individual)
Floor Hockey ☐	Basketball ☐	Badminton ☐	Archery ☐	Batting ☐
Soccer ☐	Softball ☐	Horseback ☐	Bowling ☐	Crawling ☐
Touch Football ☐	Volleyball ☐	Shop ☐	Golf ☐	Hop/Jump ☐
		Swimming ☐	Ping Pong ☐	Kicking ☐
		Track ☐	Shuffle Board ☐	Skipping ☐
			Walking ☐	Throwing ☐

ABLE is an adventure bases learning experience involving a classic ropes course of climbing. Students wear full harness, helmet and have adults spotting them.

Restricted Until: _____ **Diagnosis:** _____

Telephone No: _____ **Address:** _____

Signature: _____ **Print Name:** _____ **Date:** _____

Form must be completed & signed by Physician, Nurse Practitioner, or Physicians Assistant licensed to practice in NYS