**PHYSICIAN'S RECOMMENDATION FOR**
**LIMITED PHYSICAL EDUCATION/PHYSICAL ACTIVITES**

Cc:
☐ Teacher(s)
☐ PE Teacher
*Office use only*

Date: ___________________

Dear Physician:
All students enrolled in the public schools participate in physical education activities, which are designed to meet their growth and developmental needs. In addition, many students participate in other types of physical activities such as intramural programs, inter-school athletics, band, etc.

Please provide us with the information listed below so that we can provide appropriate activities for this student.

**Student name**: ____________________________________ **Date of Birth**: ___________________
**School**: _______________________ **I.D. #** __________ **Grade**:_______ **Room#** __________

**I have examined this child and find the following**: ___________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

**Diagnosis**: __________________________________________________________________
**Prognosis**: __________________________________________________________________
_____________________________________________________________________________

Please Check Those Activities to be **AVOIDED**:

**Aerobic Activities**

- O Running/Jogging
- O Dance
- O Push-Ups/Chin-Ups
- O Sit-Ups
- O Jumping
- O Gymnastics
- O Swimming
- O Badminton
- O Wrestling
- O Basketball
- O Football
- O Soccer
- O Softball
- O Tennis
- O Volleyball
- O Calisthenics
- O Other: _______________

**Moderate Activities**

- O Golf
- O Modified Ball Activities
- O Light Calisthenics
- O Frisbee
- O Rhythms
- O Climbing on Bars
- O Swinging
- O Walking the Track
- O Other:

**Individual Fitness Activities**

- O Range of Motion Exercises
- O Shoulder/Chest
- O Upper Back/Torso
- O Lower Back/Buttocks/Hips
- O Legs/Ankles
- O Strength Exercises
- O Neck/Shoulders
- O Arms/Wrist
- O Abdomen
- O Upper/Lower Back
- O Legs/Calves
- O Weight Training
- O Weight Range Use:
- O Upper Body
- O Torso/Abs./Back
- O Lower Back
- Other:
- O _________________

The Above Restricted Program is Recommended Until: ________________________________________
(Estimate in weeks or months)

Physician Signature & Stamp: ______________________________
Physician's Name: ___________________________ Physician's Phone Number: ________________
Parent's Signature: ___________________________