DOWNEY UNIFIED SCHOOL DISTRICT

LIMITED PHYSICAL ACTIVITY

School Year _________________

Name of Student: _______________________________________ D.O.B. ________________

Disability or medical condition that requires the student to have limited activity:

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Limited Activity is recommended until: ____

Student's Height: ___________________ Weight: ____________________

Can the student bear weight? ☐**Yes** ☐**No**

Can the student be placed in an appropriate device for weight bearing (ie. stander, tilt table, Rifton, etc.)? ☐**Yes** ☐**No**

Does this student require ☐ **wheelchair** ☐**walker** ☐ **brace** ☐ **cane** ☐**cast** ☐ **prosthesis**

Physician's recommendations:

(Please describe in detail to assure proper implementation and compliance)

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Please list any special equipment student may need during school:

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______________________________________ ______________________________________

Parent/Guardian Signature Date Physician Signature & Stamp Date