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:

_____

_____

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)

_____

_____

Please list any special equipment student may need during school:

_____

_____

_____

Parent/Guardian Signature Date

_____

Physician's Signature Date

Office Stamp - REQUIRED

Revised 07/23