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's Name: _____

Physician's Signature & Date:_____

Parent's Signature: _____

Office Stamp - REQUIRED