Physician's Recommendations for Physical Activity

Student Name: ____DOB: _______________ Grade: ___________

Charter School: ☐ River Springs ☐ Citrus Springs ☐ Empire Springs ☐ Vista Springs ☐ Pacific Springs ☐ Harbor Springs ☐ Inland Empire Springs

Site/Program: ____ PE Teacher: ____________________________

Parent Name (print): ____ Date: ___________________

Parent Signature: ____ Date: ___________________

DURATION:

The student's physical activities will be limited for the following period of time: _____________________________

PERMISSION TO BE IN SCHOOL WITH: ☐ **Cast** ☐ **Crutches** ☐ **Wheelchair** ☐ **Sling** ☐ **Other**

RECOMMENDATION FOR RECESS/LUNCH/PHYSICAL EDUCATION PROGRAM:

- May participate in all activities and Physical Education Program WITHOUT RESTRICTIONS
- MAY NOT PARTICIPATE in any physical activity or Physical Education Program during the dates listed above.
- The student may be assigned a "Safe Area "per school policy during recess/lunch or physical education class.
- May participate in LIMITED PHYSICAL EDUCATION ACTIVITIES, check below:

☐ Walking
☐ Dance
☐ Flexibility/Stretching/Yoga
☐ Jogging

☐ Jumping
☐ Walking Stairs
☐ Running
☐ Swimming

☐ Upper Body Weight Lifting
☐ Lower Body Weight Lifting
☐ Other__________________
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Additional Recommendations/Restrictions:

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Physician Name (printed):____ Phone: ____________________________

Physician Signature: ____ Date: ______________________________

Return Fax: 951-489-0494 or email: school.nurse@springscs.org