



Physician's Recommendations for Physical Activity

Student Name: _____ DOB: _____ Grade: _____

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:

- | | | |
|--|---|--|
| <input type="checkbox"/> Walking | <input type="checkbox"/> Jumping | <input type="checkbox"/> Upper Body Weight Lifting |
| <input type="checkbox"/> Dance | <input type="checkbox"/> Walking Stairs | <input type="checkbox"/> Lower Body Weight Lifting |
| <input type="checkbox"/> Flexibility/Stretching/Yoga | <input type="checkbox"/> Running | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Jogging | <input type="checkbox"/> Swimming | _____ |

Additional Recommendations/Restrictions:

Physician Name (printed): _____ Phone: _____

Physician Signature: _____ Date: _____