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

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 Signature Date

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