

**PHYSICIAN'S RECOMMENDATION FOR
LIMITED PHYSICAL EDUCATION/PHYSICAL ACTIVITIES**

Cc: <input type="checkbox"/> Teacher(s) <input type="checkbox"/> PE Teacher <i>Office use only</i>

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

- Running/Jogging
- Dance
- Push-Ups/Chin-Ups
- Sit-Ups
- Jumping
- Gymnastics
- Swimming
- Badminton
- Wrestling
- Basketball
- Football
- Soccer
- Softball
- Tennis
- Volleyball
- Calisthenics
- Other: _____

Moderate Activities

- Golf
- Modified Ball Activities
- Light Calisthenics
- Frisbee
- Rhythms
- Climbing on Bars
- Swinging
- Walking the Track
- Other:

Individual Fitness Activities

- Range of Motion Exercises
- Shoulder/Chest
- Upper Back/Torso
- Lower Back/Buttocks/Hips
- Legs/Ankles
- Strength Exercises
- Neck/Shoulders
- Arms/Wrist
- Abdomen
- Upper/Lower Back
- Legs/Calves
- Weight Training
- Weight Range Use:
- Upper Body
- Torso/Abs./Back
- Lower Back
- Other: _____

The Above Restricted Program is Recommended Until: _____
(Estimate in weeks or months)

Physician Signature: _____
Physician's Address: _____
Parent's Signature: _____

Physician's Name: _____
Physician's Phone Number: _____