

PHYSICAL EDUCATION RESTRICTIONS

Student _____

School _____

Nurse: _____

Nurse's Fax: _____

Modifications for participation are made based on the extent of the injury/illness and the doctor's prescription for activity. If possible, the injured or ill student is expected to participate in some manner each day. With a coordinated effort, we hope to continue the improvement of the student's personal fitness.

PLEASE CHECK THE ACTIVITIES IN WHICH YOUR PATIENT MAY NOT PARTICIPATE

Low Intensity

- Aerobics
- Archery
- Bowling
- Change into P.E. attire
- Fishing
- Frisbee
- Golf
- Manipulatives
- Orienteering (compass skills)
- Personal Conditioning
- Shuffleboard
- Stretching/Flexibility
- Walking
- Weight Training
 - ____ Upper body
 - ____ Lower body
 - ____ Core
- Written Assignments
- Climbing Wall

Moderate Intensity

- Aerobics
- Dance Techniques
- Frisbee
- Jogging (short intervals)
- Kickball
- Personal Conditioning
- Rhythmic Dancing
- Scooter Activities
- Softball
- Table Tennis
- Track & Field
- Tumbling
- Volleyball
- Walking (moderate pace)
- Weight Training
 - ____ Upper body
 - ____ Lower body
 - ____ Core
- Climbing Wall

High Intensity

- Aerobics
- Badminton
- Basketball
- Dance Techniques
- Fitness Games
- Flag Football
- Floor Hockey
- Jogging (sustained)
- Personal Conditioning
- Physical Fitness Test
- Push-ups
- Rhythmic Dancing
- Roller Blading
- Rope Jumping
- Scooter Activities
- Self Defense
- Sit-ups
- Soccer
- Stationary Bike
- Stairmaster
- Tae Bo
- Tennis
- Track & Field
- Tumbling
- Ultimate Frisbee
- Weight Training

Beginning Date _____ Ending Date _____

(OVER)

Comments (Please include additional activities you feel would benefit this student.)

_____ Physician's Signature	_____ Print Physician's Name
_____ Date	_____ Address
_____ Phone	_____

In cases where medical conditions prevent the student's participation in all activities within the physical education curriculum, modified activities will be arranged by the physical education teacher. No student is exempt from the physical education requirement.

Thank you for helping us facilitate the physical well-being of this student,

_____ Registrar	
_____ School	
_____ Address	
_____ City	_____ Zip
_____ Phone	

Dear Parent: This confidential information will be shared only with appropriate school district personnel such as the physical education teacher, registrar, administrator, or school nurse.

_____ Parent Signature	_____ Date
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