

COMMITTED TO EXCELLENCE

STEPHANIE GAGE, RN
Director of Health Services

PHYSICIAN'S RECOMMENDATION FOR P.E. OR SPORTS PARTICIPATION

STUDENT NAME _____ **DOB** _____ **SCHOOL** _____ **GRADE** _____

TO THE PHYSICIAN: If this student is unable to participate in a full physical education program, please indicate the appropriate activity levels below.

VIGOROUS: Activities involving all-out effort to develop cardiovascular endurance, muscular strength, and fitness. Check all appropriate levels:

- _____ Collision: football, rugby, hockey, etc.
- _____ Contact: basketball, baseball, soccer, wrestling, etc.
- _____ Non-contact: cross country, swimming, track, tennis, etc.
- _____ Other: bowling, golf, archery, field events, etc.

MODIFIED: Activities for students who are unable to participate in the full program, who need concentration on a particular activity, or who need protective gear or preparation for participation.

_____ **PROTECTIVE GEAR OR PREPARATION** is needed for participation (e.g., protective eyewear collision or contact sports, knee brace for running activities, inhaler prior to vigorous activities, etc.).

_____ **ACTIVITIES TO BE AVOIDED** (e.g., running, throwing, jumping, exposure to cold air below 40 degrees F.) Be specific:

_____ **ACTIVITIES TO BE ENCOURAGED** (e.g., endurance activities such as fast walking, running, or swimming; flexibility activities such as ..., etc.) Be specific:

_____ **INDIVIDUAL PHYSICAL EDUCATION PLAN** must be developed (e.g., ROM for upper arms, breathing exercises for COLD or COPD students, etc.).

- _____ Prescribed plan attached
- _____ Contact doctor's office for guidelines

The above modification(s) need to be in effect for the following dates:

_____ Beginning date _____ Ending Date

_____ Re-evaluation needed before release for participation.

I certify that this student is under my continuing care, which will include monitoring the student's continuing need for services prescribed and/or for modification of his/her physical education program.

Signature of Licensed Physician

Date

Office Telephone