Office of the School Nurse

ADAPTIVE PHYSICAL EDUCATION RECOMMENDATIONS

Name: _____Birthdate: _____

Teacher: _____ Grade:_____

To Be Completed By Physician

Diagnosis or description of condition

_____

_____

Condition is: _____ Permanent _____ Temporary

If temporary, when may unrestricted activity resume?

_____

Functional restrictions:
This condition is such that the intensity and type of activities should be restricted as follows:

_____ No competitive sports;
_____ Activities should stop short of excessive fatigue or undue stress.
_____ No contact sports; other activities allowed.
_____ Moderate exercise with all running, jumping and gymnastics excluded.
_____ Minimal activity; training in coordination only. Simple non-strenuous activity.
_____ Avoid activities involving the following areas or extremities:
_____ Recommended exercise:

_____

_____ _____

Signature/Stamp of Physician Date

Please call if there are any questions:_____

School and Phone Number