REQUEST FOR PHYSICAL EDUCATION (PE)/PHYSICAL ACTIVITIES MODIFICATION

Student's name: _____ **DOB:** _____

Student Number: _____

Address: _____ **Phone:** _____

School: _____ **Grade:** _____

Signature of Parent/Guardian: _____ **DATE:** _____

*Above signature by parent/guardian to also serve as authorization to discuss medication/health with _____ prescribing physician.

To be Completed by Physician:

Diagnosis: _____

MAY DRESS OUT for PE class: Yes_____ No_____   **MAY participate in RECESS activities: Yes_____ No_____**

MAY participate *as tolerated* in the following activities (check all that apply):

_____ Running	_____ Pushing/Pulling	_____ Hitting	_____ Ball Sports
_____ Walking	_____ Jumping	_____ Fitness Testing	_____ Weightlifting
_____ Stretching	_____ Throwing	_____ Aerobic Activity	_____ Sit-ups
_____ Bending	_____ Catching	_____ Racket Sports	_____ Pull-ups
_____ Twisting	_____ Kicking	_____ Contact Sports	_____ Other:

MAY participate in the following activities (check all that apply and list accomodations below):

_____ Aerobics	_____ Cross Country	_____ Hockey	_____ Track
_____ Archery	_____ Diving	_____ Lacrosse	_____ Volleyball
_____ Baseball	_____ Field Events	_____ Soccer	_____ Weight Training
_____ Basketball	_____ Football	_____ Softball	_____ Other
_____ Bowling	_____ Golf	_____ Swimming	
_____ Cheerleading	_____ Gymnastics	_____ Tennis	

RECOMMENDED ACCOMMODATIONS:

[ ]

COMMENTS/INSTRUCTIONS:

[ ]

Date student may return to PE/physical activities with NO limitations: _____

If unknown, date of next appointment: _____

Medical Provider's Signature (MD, DO, NP, PA): _____ **Date:** _____

Address: _____   **City/State:** _____   **Phone:** _____