Physical Activity Physician's Recommendations

Student: _____ **Date:**_____

Date of Birth: _____ **School:** _____

PE Teacher: _____ **Grade:** _____

DURATION:

The student's physical activities will be limited for the following period of time: _____.

PERMISSION TO BE IN SCHOOL WITH: ☐ Cast ☐ Crutches ☐ Wheelchair ☐ Sling ☐ Other

RECOMMENDATION FOR RECESS/LUNCH/PHYSICAL EDUCATION PROGRAM:

☐ May participate in all activities and Physical Education Program **WITHOUT RESTRICTIONS.**

☐ **MAY NOT PARTICIPATE** in any physical activity or Physical Education Program during the dates listed above.

*The student may be assigned a **"Safe Area"** per school policy during recess/lunch or physical education class.*

☐ May participate in **LIMITED PHYSICAL EDUCATION ACTIVITIES.**

By checking a box below provides authorization for the student to participate in the physical activity.

NOTE: School District Practice does NOT allow a student with a cast/ orthopedic appliance to actively participate in the Physical Education Program with the exception of a walking class.

☐ Walking	☐ Jogging	☐ Swimming
☐ Dance	☐ Jumping /Plyometrics / Walking Stairs	☐ Weight Lifting ☐ Upper Body Only ☐ Lower Body Only
☐ Flexibility/Stretching/ Yoga	☐ Running	☐ Other

Additional Recommendations/Restrictions:

_____

_____

_____

Physician's Signature **Phone Number** **Date**

_____ _____ _____

Parent's Signature **Phone Number** **Date**

TVUSD USE ONLY

_____

IMPEP REQUEST BY: *SIGNATURE* *DATE*

☐ P.E. TEACHER ☐ NURSE ☐ COUNSELOR ☐ IMPEP REQUESTED

Copy To: *Health Office (Original)* *Counselor* *Physical Education Teacher*