PAJARO VALLEY UNIFIED SCHOOL DISTRICT
Department of Special Services
294 Green Valley Road, Watsonville, CA 95076

Physical Education Modification

Please bring this form to your child's doctor or clinic if s/he has a health condition that limits or prevents participation in PE class at school. *Favor de llevar esta forma a su clínica o médico si su niño/a no puede participar en su clase de educación físico o si tiene limitaciones.*

STUDENT'S NAME/*nombre*: _____ DATE/*Fecha*: _____

BIRTHDATE/*fecha de nacimiento*: _____ GRADE/*grado*: _____

C/O/*problema*: _____

_____

_____

School Nurse/*enfermera* _____

Parent/*padre o madre*: I give permission for health care provider – school to exchange health information for school academic planning. ***Le doy permiso a la clínica o al médico para cambiar su información con la escuela.***

Parent Signature/*firma*:_____ Date/*fecha*_____

Physician's Recommendation for Modified Activity

The physical education teachers seek the advice and cooperation of physicians and parents to provide a beneficial education program for all students. Please complete this form to help us establish an activity program specifically designed for our student under your care.

Date of Exam:_____ Physician's Name_____Phone_____

Diagnosis or description of the condition_____

_____

Length of time in modified activity_____Is student able to dress for PE? _____

Please check the acceptable group of activities

☐ Fairly vigorous activities at 75% with NO PHYSICAL CONTACT INVOLVED.
☐ Moderate activities which DO NOT INVOLVE RUNNING
☐ Severely restricted which involves NO PHYSICAL ACTIVITIES
☐ Other. If an exercise or physical therapy program has been provided for this student, please attach acopy._____

_____

Date s/he may resume normal activities _____ with____/without_____ brace or joint support
☐ If permanent modifications are required, please specify here. _____

_____

Physician's Signature_____ Phone_____ Fax_____