

BAY SHORE UNION FREE SCHOOL DISTRICT
 Department of Health, Physical Education and Athletics
 75 West Perkal Street
 Bay Shore, New York 11706

Physical Education Medical Recommendation Form

To Dr. _____ Date _____

Re: Diagnosis: _____

Your patient is registered in this school district and has indicated an inability to participate fully in the regular physical education program. Kindly complete this form and return it to his/her school. Thank you for your cooperation. If you have any questions, please call School Nurse: _____ at (631) _____

NO RESTRICTIONS

MODIFIED RESTRICTIONS

Indicate the type of restrictions:

- | | | | |
|---|---------------------------------------|---|--|
| <input type="checkbox"/> Throwing | <input type="checkbox"/> Bending | <input type="checkbox"/> Ducking | <input type="checkbox"/> Hopping |
| <input type="checkbox"/> Catching | <input type="checkbox"/> Twisting | <input type="checkbox"/> Pulling | <input type="checkbox"/> Climbing |
| <input type="checkbox"/> Kicking | <input type="checkbox"/> Hitting | <input type="checkbox"/> Body Contact | <input type="checkbox"/> Running |
| <input type="checkbox"/> Walking | <input type="checkbox"/> Lifting | <input type="checkbox"/> Turning | <input type="checkbox"/> Treadmill |
| <input type="checkbox"/> Tumbling | <input type="checkbox"/> Stretching | <input type="checkbox"/> Outdoor Activities | <input type="checkbox"/> Other (Specify) |
| <input type="checkbox"/> Stationary Bike | <input type="checkbox"/> Stair Master | <input type="checkbox"/> Rowing Machine | |
| <input type="checkbox"/> Elliptical Trainer | <input type="checkbox"/> Balancing | | |

Re-evaluation Date: _____

This is to certify that I have examined the above patient and recommended that his/her physical education program be modified to the above until (date) _____

Additional Physician's Remarks: _____

Physician's Signature _____ Date _____