MENLO PARK CITY SCHOOL DISTRICT

Student Services Department
181 Encinal Avenue, Atherton, CA 94027
(650) 321-7140 Fax: (650) 292-2200

Original to Health File.

Cc: Teacher, PE teacher

PHYSICAL ACTIVITY MODIFICATION

Date: _____ Check Site: ☐Heritage Oak ☐Laurel ☐Encinal ☐Oak Knoll ☐Hillview

Student: _____ DOB: _____

Teacher: _____ Grade: _____

PART I: COMPLETED BY PARENT/GUARDIAN: This form must be completed by your child's health care provider for any health condition that limits or prevents participation in any physical activities at school, including school sponsored programs. **Return this form to the school office.** *El proveedor de atención médica de su hijo debe completar este formulario para cualquier condición médica que limite o impida la participación en cualquier actividad física en la escuela, incluidos los programas patrocinados por la escuela.* ***Devuelva este formulario a la oficina de la escuela.***

Problem/*problema*_____

_____

School Nurse/other designated staff *enfermera/el otro personal señalado*_____

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 clinica o al medico para cambiar su información con la escuela.***

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

PART II: COMPLETED BY HEALTH CARE PROVIDER:

In order to provide a beneficial education program, please complete this form in its entirety to help establish an activity program specifically designed for this student under your care. If an exercise or physical therapy program has been provided for this student, please attach a copy.

Date of Exam:_____ Diagnosis or description of the condition:_____

_____

1. The student is able to return to school, recess and school sponsored events (e.g., after-school activities) with the following **LIMITATIONS** for _____ days / weeks / months (circle one):

□ No contact sports □ Self-limited/As tolerated PE □ No PE/activities □ No limitations

□ Modified PE/activities - specify: _____

List specific movements that should/must be avoided: _____

List any needed durable medical equipment (DME): _____

☐ If **PERMANENT modifications** are required, specify here: _____

2. Check below the PE activities in which the student **CAN** participate:

□ Running (cardiovascular) □ Calisthenics/warm-up exercise □ Jumping □ Non-Contact Sports

□ Lower Body Workout □ Upper Body Workout □ Walking □ light jogging

□ Stretching □ Other: _____

Projected date normal activities may resume: _____ with / without (circle one) brace or joint support.

Follow up appointment scheduled for _____

Health Care Provider Signature_____ **Date:** _____

Printed Name/Stamp _____ **Phone:** _____