

STUYVESANT HIGH SCHOOL

345 Chambers St. New York, NY 10282

PHYSICAL EDUCATION MEDICAL RECOMMENDATION FORM

TO DR. _____ DATE: _____

All students registered in the schools of New York State are required by New York State Education Law and Commissioner's Regulations to attend courses of instruction in physical education. These courses must be adapted to meet individual student needs if the student has medical limitations. This means that a student who is unable to participate fully in their physical education program must have activities modified to meet his/her individual needs.

Your patient, _____, is registered in this school district and has indicated an inability to participate fully in the physical education program. To assist us in designing a program adapted to meet his/her individual needs, would you kindly complete this form and return it to his/her school. Thank you for your cooperation!

Diagnosis: _____ Mild: ____ Moderate: ____ Severe: ____

Is this disability temporary or permanent? _____

Current treatment: _____

Anticipated completion date of treatment: _____

Indicate with an **M** where a modification is recommended. Indicate with an **N** where no participation is recommended:

TEAM SPORTS

INDIVIDUAL/DUAL ACTIVITIES

____ All

____ Soccer

____ Flag Football

____ Field Hockey

____ Team Handball

____ Gym Hockey

____ Basketball

____ Volleyball

____ Softball

____ All

____ Track & Field

____ Aerobics

____ Golf

____ Paddleball

____ Fencing

____ Gymnastics

____ Yoga

____ Fitness

____ Weight Training

____ Dance

____ Archery

____ Tennis

____ Badminton

____ Handball

____ Wall Climbing

____ Pilates

____ Cardio-Kickboxing

Modifications recommended: _____

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

(Date)

Are there any exercises or activities you feel would be beneficial to the student in the recovery process? Yes ____ No ____ If so, what? _____

Additional Physician's Remarks (on back)

(Physician's Signature)

(Date)

NOTE: This report will be attached to the student's health record with duplicates sent to the parent/guardian, physical education teachers, and director of physical education and Committee on Special Education where appropriate.