RIVERSIDE UNIFIED SCHOOL DISTRICT
Medical Information Form - Grades 7-12
For Physical Education Modifications

Student _____ Date of Birth _____ Grade _____ School _____

Note to Physician: Participating in Physical Education activities/classes is a critical component of a student's educational program. Please complete this form so that the above named student, with a medical disability or injury, may participate in physical education (P.E.) **as required by California Education Code. (California Education Codes 51206, 51210, 51211, 51220, 51223)** ***Note: Participation in Physical Education is a California State Board of Education and Riverside Unified School District graduation requirement.***

The above student has the diagnosis of _____

Please check **YES or NO** for **EACH** of the movements/activities that are appropriate for your patient. All information received is **confidential.**

Appropriate Types of Activity

Flexibility/Strengthening

YES	NO	
_____	_____	Muscle strengthening
_____	_____	Stretching
_____	_____	Weight training
_____	_____	Push-ups
_____	_____	Sit –ups
_____	_____	Core Work
_____	_____	Resistance Bands

Cardiovascular/Aerobic

YES	NO	
_____	_____	Speed Walking
_____	_____	Stair Climbing
_____	_____	Jump Rope
_____	_____	Intermittent Walk/Jog
_____	_____	Jogging
_____	_____	Sprinting
_____	_____	Swimming
_____	_____	Dance
_____	_____	Aerobic Activities-_____

General Movement

YES	NO	
_____	_____	Bending
_____	_____	Jumping
_____	_____	Lifting
_____	_____	Kicking
_____	_____	Throwing
_____	_____	Catching
_____	_____	Hitting Activities

_____ **Student may return to school with (please circle): crutches walker wheelchair knee scooter**

Indicate Specific Recommended Modifications _____

_____

Above restrictions/modifications in effect from _____ **to** _____.

Thank you for assisting in planning for this student's physical education modifications at school.

Physician Signature _____ Date _____

Physician printed name or stamp _____

Physician Phone# _____ Fax# _____

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I give permission for school or district personnel to contact the physician for consultation and exchange of information as needed.
Parent/Guardian Signature _____ Date _____

Please return completed form to School Health Office. Medical information provided must be verified by District Nurse. School must be notified if there is a change or modification in physical education or activity restrictions.

District Use Only

I have reviewed the above information and recommend: ☐ regular PE ☐ modified PE* ☐ other _____

District Nurse Signature: _____ Date: _____

Physical Education Teacher Signature: _____ Date: _____
*physical activities modified on an individual basis according to physician's recommendation as indicated above

No Physical Activity Indicated: 2nd Medical Information Form Sent to Dr. for recommended modifications: ☐
I have reviewed the above information and recommend: ☐ regular PE ☐ modified PE* ☐ other _____

District Nurse Signature: _____ Date: _____

Cc: ☐ Nurse ☐ Health Office ☐ Counselor ☐ Physical Education Teacher

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