RECOMMENDATION FOR LIMITED

PARTICIPATION IN PHYSICAL EDUCATION

Temporary exemption from physical education may be granted to pupils who are ill or injured (California Education code 51241). A doctor's excuse and recommendation is required. Please ask your health care provider to complete the following report and return to the School Nurse.

I hereby authorize exchange of information between MD_____ and _____ School.

Date: _____ Signature of Parent/Guardian _____

TO THE EXAMINER: Student's Name: _____ Student's DOB: _____

is unable to participate in a regular education program for _____ days ____ weeks _____months.

Diagnosis: _____

PLEASE SPECIFY THE LIMITED PARTICIPATION ACTIVITIES THE STUDENT MAY PARTICIPATE IN BELOW BY CHECKING THE SPECIFIC ACTIVITY AS YES OR NO:

For 9th thru 12th grade students (students are required two years of PE as a high school requirement to graduate):

Yes	No		Yes	No	
____	____	Racquet Sports	____	____	Soccer
____	____	Frisbee	____	____	Flag Football
____	____	Basketball	____	____	Tumbling/Gymnastics
____	____	Track & Field	____	____	Dance/Aerobics
____	____	Volleyball	____	____	Baseball
____	____	1.5-mile run timed	____	____	Walking (timed Yes or No)

Warm up activities:			Warm up activities:		
____	____	jumping jacks	____	____	Lounges, squats
____	____	crunches, sit-ups	____	____	push-ups
____	____	Stretching upper extremities	____	____	stretching lower extremities
____	____	Twisting and bending trunk	____	____	light job around gym/blacktop

Student can participate in alternative activities that require no exertion, such as:

Yes	No	
____	____	Quiet games involving almost no exertion
____	____	Hobbies and crafts
____	____	Other Homework, such as reading or writing
____	____	Teacher Assistance Work (students who are expected to be removed from PE for more than 20 school days will be placed in a medical TA position or placed in another class as space limits)

Additional Comments: (Please be specific) _____

_____

WHAT SHOULD THE STUDENT DO AT END OF THE DESIGNATED TIME?

1. Return to health care provider for recheck_____

2. Engage in regular physical education activities_____

Date:_____ Physician Name (Office Stamp if Available)

Physician's Signature_____