



Eden Central School District

3150 Schoolview Road
Eden, New York 14057

Mr. Jeffrey A. Sortisio
Superintendent
(716) 992-3629

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Director of Pupil Personnel Services
(716) 992-3645

PHYSICAL EDUCATION MEDICAL RECOMMENDATION FORM

TO DR. _____ DATE: _____
Physician Name

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 had 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!

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

- | | | |
|-----------------------------------|-------------------------------------|--|
| <input type="checkbox"/> Throwing | <input type="checkbox"/> Bending | <input type="checkbox"/> Pushing |
| <input type="checkbox"/> Catching | <input type="checkbox"/> Twisting | <input type="checkbox"/> Pulling |
| <input type="checkbox"/> Kicking | <input type="checkbox"/> Hitting | <input type="checkbox"/> Body Contact |
| <input type="checkbox"/> Running | <input type="checkbox"/> Walking | <input type="checkbox"/> Water Activities |
| <input type="checkbox"/> Lifting | <input type="checkbox"/> Jumping | <input type="checkbox"/> Out of Doors Activities |
| <input type="checkbox"/> Tumbling | <input type="checkbox"/> Stretching | <input type="checkbox"/> Other (Specify) |

Modifications recommended: _____

This is to certify that I have examined the above patient and recommend 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 when appropriate.