BAY SHORE UNION FREE SCHOOL DISTRICT

Department Of Health, Physical Education and Athletics

Bay Shore, New York 11706

Physical Education Medical Recommendation Form

To Dr. _____ Date _____

Re: _____ Diagnosis: _____

Your patient is registered in this school district and has indicated an inability to participate fully in the regular physical education program. Kindly complete this form and return it to his/her school. Thank you for your cooperation. If you have any questions, please call School Nurse: _____ at (631) _____

NO RESTRICTIONS (___)

MODIFIED RESTRICTIONS (___)

Indicate the type of restrictions:

Throwing	Bending	Pushing	Hanging
Catching	Twisting	Pulling	Climbing
__Kicking	__Hitting	__Body Contact	__Running
Walking	Lifting	Jumping	Treadmill
Tumbling	Stretching	Outdoor Activities	Other (Specify)
__Stationary Bike	__Stair Master	__Rowing Machine	
__Elliptical Trainer	__Balancing		

NO PHYSICAL ACTIVITY IS PERMITTED UNTIL FURTHER EVALUATION (___)

Re-evaluation Date: _____

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

Additional Physician's Remarks:

_____ _____

Physician's Signature Date

Physician's Stamp: