BAY SHORE UNION FREE SCHOOL DISTRICT

Department of Health, Physical Education and Athletics

75 West Perkal Street

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: