

**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**

<b><u>Flexibility/Strengthening</u></b>		<b><u>Cardiovascular/Aerobic</u></b>		<b><u>General Movement</u></b>								
<b>YES</b>	<b>NO</b>	<b>YES</b>	<b>NO</b>	<b>YES</b>	<b>NO</b>							
_____	_____	_____	_____	_____	_____	Muscle strengthening	_____	_____	Speed Walking	_____	_____	Bending
_____	_____	_____	_____	_____	_____	Stretching	_____	_____	Stair Climbing	_____	_____	Jumping
_____	_____	_____	_____	_____	_____	Weight training	_____	_____	Jump Rope	_____	_____	Lifting
_____	_____	_____	_____	_____	_____	Push-ups	_____	_____	Intermittent Walk/Jog	_____	_____	Kicking
_____	_____	_____	_____	_____	_____	Sit-ups	_____	_____	Jogging	_____	_____	Throwing
_____	_____	_____	_____	_____	_____	Core Work	_____	_____	Sprinting	_____	_____	Catching
_____	_____	_____	_____	_____	_____	Resistance Bands	_____	_____	Swimming	_____	_____	Hitting Activities
									Dance			
									Aerobic Activities-			

**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# \_\_\_\_\_

\*\*\*\*\*  
 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:** 2<sup>nd</sup> 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