SCHOOL DISTRICT OF TOMAHAWK

TOMAHAWK COMMUNITY SCHOOL DISTRICT
PHYSICIAN'S RECOMMENDATIONS FOR PHYSICAL EDUCATION RESTRICTIONS

Name_____ **DOB**_____

Address_____ **Phone**_____

School_____ **Teacher**_____ **Grade**_____

Instructions: to be filled out by physician. **Date**_____
Diagnosis or description of the conditions_____

_____

_____

Condition: Permanent_____ **Temporary**_____ **Date may return to activity**_____

I recommend the following: (check the appropriate item or items)

___ **1. No restrictions on activities in physical education**
___ **2. No competitive sports: In other activities, should stop short of excessive fatigue or undue stress.**
___ **3. No contact sports: other activities allowed**
___ **4. No running or jumping**
___ **5. No tumbling**
___ **6. Avoid activities involving upper extremities.**
___ **7. Avoid activities involving lower extremities**
___ **8. Avoid activities involving neck, back or abdomen.**
___ **9. Recommend the following exercises:** _____
_____
___ **10. Other specific adaptations or functional limitations:** _____
_____

I recommend the adaptations for: _____ **period of time.**

Physician Signature: _____

PLEASE RETURN THIS FORM WITH THE STUDENT TO SCHOOL OR FAX IT TO 715-453-5903 ATTENTION SCHOOL NURSE.

The Nurse of the Tomahawk School District may contact you for further clarification if necessary. Appropriate accommodations can be made for all students to participate in physical education to some extent.

Parent Signature_____ **Date** _____