ADAPTIVE PHYSICAL EDUCATION RECOMMENDATION

This form is to be completed by your physician if your child's physical education activities are restricted. This form is to be used to consult at your child's IEP Team (M-team) meeting.

Student:_____ Date of birth:_____
School:_____

_____ is a patient of mine and is unable to participate in physical education activities due to activity intolerance related to:

_____Anatomic impairment (cardiac / other): _____

_____Developmental delay (physical maturation / other): _____

_____Health status, altered (general / body / muscular weakness secondary to): _____

_____

_____Oxygen supply / demand imbalance, secondary to:_____

_____Physiology, altered (breathing pattern, ineffective / other): _____

_____Other (specify diagnosis or description of the condition): _____

Condition is: _____ Permanent
_____ Temporary

If temporary, may return to unrestricted activity on _____.
Date

Functional restrictions: Child's condition is such that the intensity and type of activity should be limited. S/he is capable of participation to the extent of:

_____No competitive sports; in other activities, should stop short of excessive fatigue and undue stress.

_____No contact sports; other activity allowed.

_____Moderate exercise, with all running, jumping, and gymnastics excluded.

_____Minimal activity; training in coordination only. Simple, nonstrenuous activity.

_____I recommend the following exercise:_____

Musculoskeletal restrictions:

_____Avoid activities involving upper extremities.

_____Avoid activities involving neck, back, or abdomen.

_____Avoid activities involving the lower extremities.

Comments: Attached are recommendations and / or orders that will assist the school system on developing a health management plan and an adaptive physical education program for this child.

_____ _____ _____
Physician's signature Phone number Date

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