Release of Medical Information

CONFIDENTIAL

PARENT RELEASE:

Student Name: _____ Age: _____ Grade: 9 10 11 12

Address: _____

Parent/Guardian Name (Print): _____ Signature: _____

Home Phone: _____ Mother's work phone: _____ Father's work phone: _____

Doctor's Name: _____ Phone: _____

For Physician Use Only

1. Diagnosis: Please include type and extent of injury/illness/chronic condition and indicate necessary physical activity accommodations pertaining to each type (i.e. asthma, sprain, fracture, postural deviation, cardiac/vision/hearing...)

_____

_____

_____

2. Please indicate body areas in which activity should be modified/limited/eliminated.

_____

_____

3. Please provide activity recommendations for student's participation in Physical Education:

General Conditioning	Omit	Allow	Allow with Specified Accommodation	**Specific Activities**	Omit	Allow	Allow with Specified Accommodation
Core Exercises/Stretching				Badminton/Tennis			
Upper Body Resistance/Weights				Softball/Kickball			
Lower body Resistance/Weights				Basketball/Football			
Jumping/Jump Rope				Soccer/Handball/ Floor Hockey			
Aerobics High/Low Impact				Golf			
Jogging/Running Time or Distance				Volleyball			
Step Training/Bosu				Bowling/Beanbags			
Swimming/Life Guard Training				Other			

Comments:

The student is recommended for:

☐ Modified PE & Sports until *(please specify date)* _____

☐ Exemption from PE & Sports until *(please specify date)* _____

Doctor's Signature: _____ Date: _____

For School Use:

Is this limitation substantial enough to impact a major life activity that would require a Section 504 Plan? ___YES ___NO

Nurse's Signature: _____ Date: _____

Principal's Signature: _____ Date: _____