Clear Form

* ANNUAL PHYSICIAN'S RECOMMENDATION FOR MODIFIED ELEMENTARY PHYSICAL EDUCATION

STUDENT'S NAME _____ Age _____ Grade _____

School _____ Student I.D. No. _____

This is to certify that I have examined the above-named student. Diagnosis: (Please be specific)

_____

_____

The student (is) (is not) at present under continued medical treatment.

The student is taking medicines which could effect participation in physical education, (please explain)

_____

_____

I recommend that participation in physical education be limited to:

☐ Moderate activity such as _____

☐ Restricted activity such as _____

☐ Special activities including _____

_____

Please note that students will be expected to dress appropriately for modified physical education.

Please list additional information on and recommendations in regard to limits of capability and tolerance _____

_____ (continued on reverse side _____)

Duration: for _____ week(s); for _____ month(s); for _____

Signed: _____ , M.D. Phone _____ Date _____

TO THE PARENTS OR GUARDIAN AND TO THE FAMILY PHYSICIAN:

All students are required by the Miami-Dade County School Board to take physical education. **Public Law 94-142 requires that special programs be designed or that appropriate modifications and accommodations** be made for students with special needs. It is only in extreme cases where any degree of activity is detrimental to the student's health that physical education would not be required. Your cooperation and support will be invaluable in helping us meet the physical education needs of our

*** The medical condition requiring modified physical education must be evaluated annually.**