Livingston School District
Livingston, New Jersey 07039

Physical Education Modification Form

Student:_____ Homeroom:_____
School:_____ Fax Number:_____

Physical Education Status Form to be complete by Physician:

1. [] Was treated by the orthopedic doctor/Physician today: _____
2. [] Should be medically excused from school._____
3. [] May return to school:_____
4. [] May not participate in phys.ed./sports/activity for:_____
5. [] May return to unrestricted phys.ed./sports/activity on:_____
6. [] May return to restricted phys.ed./sports/activity on:_____
7. [] May return to full/light/restricted activity status on:_____
8. [] Allowed to take_____ medication during school.
9. [] Student will require:_____
10. [] For_____Day/Week/Month
11. [] Next Appointment:_____
12. [] Diagnosis:_____
13. [] Restrictions:_____

*If there are restrictions, and a modified physical education program is required, please complete the reverse side of this form. Thank you.

Physician Signature:_____ Date:_____

I give my permission for the above physician to fax the information contained on both sides of this form to the school nurse at the above school as soon as possible.

Parent Signature:_____ Date:_____

LIVINGSTON SCHOOL DISTRICT

PHYSICAL EDUCATION MODIFICATION PROGRAM

School_____ **Homeroom**_____

Physician_____ **Date**_____

Regarding the physical education of your patient_____, we shall appreciate your cooperation in completing this form and returning it to the school nurse at the above mentioned school.

All pupils registered in the schools of New Jersey are required by the Education Law to participate in physical education class. A pupil who is unable to participate in the entire program should have his/her activities modified to meet his/her individual needs. **Kindly check the following boxes for the condition which applies to your patient:**

[] Post Operative [] Asthmatic [] Cardiac
[] Post Injury [] Post Fracture [] Chronic Illness
[] Physical Disability – Type_____
[] Other (specify) _____

An individualized physical education program, under the direction of physical education specialists is provided for those students in need. Should your patient require such a prescribed program, please indicate that prescription under "remarks" on this form.

The following is a general list of activities included in the physical education program. Please check the boxes for the Activities in which your patient **CAN** participate:

Warm-up Activities
[] Stretching Exercises
[] Calisthenics
[] Aerobic Exercises
[] Corrective Exercises
(specify)_____
_____

Locomotor Skills
[] Skip [] Hop
[] Gallop [] Jump
[] Walk [] Jog

Strengthening Exercises
[] Arm/Shoulder
[] Hand/Wrist
[] Leg/Knee/Ankle
[] Cardiovascular
[] Abdominal

Non-Strenuous Perceptual Motor Activities
[] Simple Ball Games
[] Fine Motor Activities
[] Simple Rhythms
[] Quiet Games
[] Coordination Skills
[] Small Equipment (bean bags, ring toss, etc.)

Physical Fitness Test
[] Arm Hang From Bar
[] Abdominal Curls
[] Standing Long Jump
[] Endurance Run
[] Flexibility (sit and reach)

Active Games
[] Running Games
[] Dancing
[] Parachute Activities
[] Sport Lead-up Games

Gymnastics
[] Tumbling/Stunts/Mat Activities
[] Apparatus:
[] Low Balance Beam
[] Ropes
[] Ladder
[] Bars

This is to certify that I have examined _____, and recommend that he/she should participate only in the activities that are checked above for a period of _____ days/weeks/months.

Remarks:_____
_____
_____

Physician Signature_____ Date_____

(This report will be attached to the child's school health record and a duplicate will be made for the physical education office.)