THE SCHOOL DISTRICT OF PHILADELPHIA SCHOOL HEALTH SERVICES

PHYSICAL EDUCATION MEDICAL EXEMPTION / PROGRAM MODIFICATION

To the Parent/Guardian:

Participation in our Physical Education Program is required for all students. Modifications are available for students who are unable to participate in all parts of the program. It is your responsibility to contact the school nurse if the student requires a modified program. In cases of temporary restriction, the student is still required to report to his/her regularly scheduled physical education class and must continue to take health education classes. This form is to be completed **every school year** by your physician and returned to the school nurse. The School Nurse will forward a copy to the school Department of Physical and Health Education.

Physician: The Pennsylvania Department of Education requires ALL students to participate in a planned program of physical education at EVERY GRADE LEVEL.

STUDENT'S NAME - LAST	FIRST	M.I.	BIRTH DATE - MO/DAY/YR	PID#
NAME OF SCHOOL			GRADE	ROOM
SCHOOL NURSE			TELEPHONE	DATE ISSUED

COMPLETED BY CARE PROVIDER

Our patient has requested an excuse from the regular physical education program based on the health condition listed below:

Diagnosis: ___

1. CHECK DEGREE OF ACTIVITY PERMITTED: 2. CHECK ANYTHING WITHIN THAT CATEGORY WHICH IS NOT PERMITTED.								
		MODERATE CALISTHENICS & GENERAL EXERCISES REQUIRING MODERATE RUNNING AND MUSCULAR EFFORT)		MILD (I.E. WALKING OR MOVEMENT OF ARMS, NECK & TRUNK)				
RUNNING	SOCCER	YOGA	MEDICINE BALL	WALKING - INDOOR	TABLE TENNIS			
JUMPING	BASKETBALL	DANCE	LOW ORGANIZED GAMES	OUTDOOR	SHUFFLEBOARD			
AEROBICS	TRACK & FIELD	SOFTBALL	BADMINTON	ARCHERY	BOWLING			
YOGA	FLAG FOOTBALL	TENNIS	KICKBALL	YOGA	BALL DRILLS			
DANCE	SPEEDBALL	VOLLEYBALL	STUNTS	BADMINTON	HAND APPARATUS DRILLS			
TENNIS	GYMNASTICS	WEIGHT TRAINING	TETHERBALL	GOLF	THERAPEUTIC EXERCISES			
HOCKEY (FIELD)		THERAPEUTIC EXERCISES	ROLLER SKATING	DANCE	LOW ORGANIZED GAMES			
HOCKEY (FLOOR)		JOGGING	HANDBALL GAMES	QUOITS/HORSESHOES				
		ROPE DRILL						
RESTRICTION REQUESTED FOR WEEKS DATE OF EXAMINATION MODIFICATION REQUESTED FOR WEEKS Comments: Signature of Care Provider (REQUIRED) Telephone Care Provider office stamp (REQUIRED)								
Address			Signed					