PHYSICAL EDUCATION RESTRICTIONS

Name ____

Diagnosis ____

The following Physical Education restrictions are recommended:

___ Regular Program	___ No Physical Education
___ After School Sports	___ No Contact Sports
___ No Running	___ No Gymnastics
___ No Dressing Out	___ No Showers
___ Precipitous Heights	___ Swimming

Restricted Activity____

____

Time Limit: Days, beginning ____________________________________

Weeks, beginning ____________________________________

This semester ______________________________________

__________ ______________________________________

Date Physician's Signature (Print)

____

Physician's Signature (Sign)

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