Livermore Valley Joint Unified School District

685 East Jack London Boulevard, Livermore, CA 94551
Tel (925) 606-3200 Fax (925) 606-3329

Request for Physical Education Restrictions/Limitations

Student Name: _____ Date of Birth: _____

School: _____

Physician's Authorization (This form is valid only through July 31st of the current school year.)

Student Diagnosis: _____

Estimated total duration of limitation: From _____ To _____

Complete Inactivity Needed? Yes _____ No _____ From _____ To _____

☐ Regular physical education program, or activity level with no modifications required.

☐ Due to my patient's condition, I have prescribed complete rest and inactivity during physical education class and any extracurricular sports/physical activities until the date of _____.

☐ I have indicated the activities my patient can/can not participate in below:

YES	NO	SPORTS
____	____	Badminton
____	____	Basketball
____	____	Dodgeball
____	____	Flag Football
____	____	Floor Hockey
____	____	Frisbee/Running Games
____	____	Floor Hockey
____	____	Pickleball
____	____	Pilates
____	____	Soccer/soccer type games
____	____	Softball
____	____	Track & Field Events
____	____	Volleyball
____	____	Weight Lifting - lower body
____	____	Weight Lifting - upper body
____	____	Yoga

YES	NO	ACTIVITIES
____	____	Calisthenics
____	____	Jumping Jacks
____	____	Push Ups
____	____	Sit Ups
____	____	Long & Vertical Jump

YES	NO	AEROBIC/OTHER
____	____	Circuit Training
____	____	Medicine balls (4-20 lbs)
____	____	Jumping rope
____	____	Resistance bands
____	____	Bosu balls (side-step/balance)
____	____	Agility activities
____	____	Stretching activities
____	____	Jogging (fast pace)
____	____	Running (moderate pace)
____	____	Walking (brisk pace)

Other: _____

Physician Signature: _____ Date: _____

Physician Name (print): _____

Provider (Kaiser, Blue Cross, etc.): _____

Address, City Zip: _____

Phone: _____

Healthcare Provider Stamp

Parent Guardian Consent

I hereby request that the school assist with the activity restriction mentioned above for my student. I give my consent for the school nurse or other designated school personnel to contact the health care provider to exchange information regarding the above orders. I will submit additional documentation from my student's health care provider when needed.

Signature of Parent/Guardian: _____ Date: _____