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.**

☐ VIGOROUS				☐ 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	Date Signed	