HARFORD COUNTY PUBLIC SCHOOLS

DEPARTMENT OF HEALTH AND PHYSICAL EDUCATION

ADAPTED PHYSICAL EDUCATION - MEDICAL RECOMMENDATION

To Whom It May Concern,

Your patient, _____, is enrolled in Harford County Public Schools at _____ School, and is scheduled to participate in physical education.

Under the Maryland State Board of Education regulation 13A.04.13.01 for physical education; there is no exemption from physical education. By law we are required to provide modifications if necessary based on the physical limitations or medical condition of the student.

In order for us to design a safe physical education program appropriately adapted to meet the student's individual needs, please complete this form and return it to _____ school fax number (_____)_____.

☐ Student has ***NO MEDICAL RESTRICTIONS/LIMITATIONS*** requiring special instructions.

☐ Student has ***TEMPORARY RESTRICTIONS/LIMITATIONS***

- Temporary restrictions are restricted activities lasting less then 10 weeks; *OR*
- Student may **resume normal activities on (date):**_____

[If no resume date is indicated, this form is valid for one year]

- ***Please complete the restrictions sections below***

Due to medical condition of _____, the student ***may participate with the following restrictions or limitations:*** *(Please check the box(s) that indicates the most appropriate level of participation for the student in each section/category)*

Functional Capacity:
☐ Unrestricted, full participation in all activities
☐ Restricted; continue completing the sections below

Cardiorespiratory Exertion:
☐ High intensity (i.e. running, sprinting, no restrictions on distance or time)
☐ Moderate intensity (i.e. jogging for up to 20 minutes at a time, power walking, aerobic dancing)
☐ Low intensity (i.e. walking)

General Musculoskeletal Impact:
☐ High impact (i.e. aerobic dancing, running, landing as in vaulting, landing as in long jump)
☐ Moderate impact (i.e. hopping, jumping)
☐ Low impact (i.e. walking, standing)

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Inversion:
☐ Skills requiring student to an inverted position, bearing weight on head or neck (i.e. forward/backward roll, tripod, headstand)
☐ Skills requiring student in an inverted position, without bearing weight on head or neck (i.e. cartwheel, handstand)
☐ No inverted positions permitted

Physical Contact
☐ Activities in which physical contact is likely to occur (i.e. basketball, soccer, floor hockey)
☐ Activities in which incidental physical contact may occur (i.e. structured drill situations, small group games)
☐ Individual skill building activities in which physical contact is not likely to occur

Strength Training
☐ LOWER body exercises using free weights, weight machines, etc.; with a maximum weight of: _____ lbs.
☐ UPPER body exercises using free weights, weight machines, etc.; with a maximum weight limit of: _____ lbs.

Please list any **other health conditions** (i.e. latex allergy, seizure, shunt, AAI, etc.) and/or medications that would impact participation in physical activity:

_____

_____

_____

_____

Additional Physician Remarks:

_____

_____

_____

_____ _____

Health Care Provider's Signature Date

_____

Health Care provider's Name (Print)

12/03/15 jw