

PATERSON PUBLIC SCHOOL

ACTIVITY LIMITATION FORM

PS#: _____ (973) 321- _____ DATE GIVEN: _____ DATE RETURNED: _____

STUDENT: _____ DOB: _____ GRADE/HR: _____

Dear Doctor:

Our records indicate that the above named student requires an individual activity plan. Please provide a diagnosis and what accommodations, if any, are needed. Will you kindly check below the activities that the student may participate in.

PROGRAM OF FULL PARTICIPATION: _____ YES _____ NO

Relating to *DIAGNOSIS*: _____

Student **MAY PARTICIPATE FULLY** in the school program **WITHOUT RESTRICTIONS**.

PHYSICIAN PRINT/STAMP: _____ PHONE: _____

PHYSICIAN SIGNATURE: _____

OR:

PROGRAM OF RESTRICTED ACTIVITY: Start date: _____ End Date: _____

Relating to *DIAGNOSIS*: _____, *the following plan is indicated.*

Student MAY PARTICIPATE in the following activities:

	YES	NO
WARM-UP EXERCISES: Stretching , walking		
LOW IMPACT AEROBICS: Jumping, hopping, jogging, dance, Zumba		
SWIMMING:		
STUNTS: Tumbling, rolling, balance, strength		
PHYSICAL FITNESS TESTING: Running, sit-ups, push-ups, pull-ups		
NON-CONTACT GAMES: Paddle ball, jump rope, badminton, tennis, bowling, other racket sports		
WEIGHT TRAINING PROGRAM: Free weights, treadmill		
TRACK AND FIELD: Sprints, intermediate & distance running, long jump, high jump, shot-put		
APPARATUS: Climbing, vaulting, support, suspension		
COMPETATIVE GAMES: Soccer, hockey, basketball, baseball, softball, volleyball, speedball, touch football		
RECESS PLAY:		

STAIR CLIMBING (Circle) : YES NO * Number of flights of stairs allowed per day _____

USE OF HELMET in gym: YES NO in recess: YES NO in class: YES NO

OTHER PROTECTIVE and/or ASSISTIVE DEVICES (please specify): _____

OTHER RESTRICTIONS: _____

PHYSICIAN PRINT /STAMP _____ PHONE: _____

PHYSICIAN SIGNATURE _____ DATE: _____

_____ INITIAL EXAM _____ ANNUAL FOLLOW UP