

HIGH SCHOOL PHYSICAL EDUCATION ACTIVITY MODIFICATION FORM

To accommodate your child's medical restrictions, please have this form completed by your doctor. Physical Education teachers will make any necessary accommodations within medical limitations.

Name _____ PE teacher _____

MD Assessment _____

Comments/ Restrictions _____

Restrictions begin _____ Restrictions end _____

Will return for evaluation _____

TARGET SPORTS

Archery ___yes ___no

Golf ___yes ___no

TEAM PASSING

Basketball ___yes ___no

Field Hockey ___yes ___no

Flag Football ___yes ___no

Floor Hockey ___yes ___no

Lacrosse ___yes ___no

Soccer ___yes ___no

Team Handball ___yes ___no

Ultimate Frisbee ___yes ___no

NET SPORTS

Badminton ___yes ___no

Pickleball ___yes ___no

Table Tennis ___yes ___no

Volleyball ___yes ___no

DANCE & AESTHETICS

___yes ___no

OUTDOOR EDUCATION

Orienteering ___yes ___no

STRIKING & FIELDING

Softball ___yes ___no

Cricket ___yes ___no

Wiffleball ___yes ___no

FITNESS ACTIVITIES

Aerobics ___yes ___no

Kickboxing ___yes ___no

Pilates ___yes ___no

Step Aerobics ___yes ___no

Tae Bo ___yes ___no

Yoga ___yes ___no

WEIGHT TRAINING

Upper Extremity ___yes ___no

Lower Extremity ___yes ___no

Running ___yes ___no

Walking ___yes ___no

Interscholastic/ Competitive Sports Participation

This student is physically qualified to participate in the following categories with no apparent contraindication:

- Yes No Contact or Collision Sports (Field Hockey, Football, Ice Hockey, Lacrosse, Soccer, Wrestling)
Yes No Limited Contact/Impact (Baseball, Basketball, Diving, Cheerleading, Handball, Skiing, Softball, Volleyball, Fencing)
Yes No Strenuous Non-Contact (Crew, Cross-Country, Track and Field, Swimming, Tennis, Weight Training)
Yes No Non-strenuous Non-Contact (Archery, Bowling, Golf)

MD Name/ Signature _____

(Date)

(MD Stamp)