

PORT WASHINGTON USFD  
PAUL D. SCHREIBER HIGH SCHOOL  
101 Campus Dr  
Port Washington NY 11050

MEDICAL OFFICE  
516-767-5860 (Fax 767-5855)  
ATHLETIC TRAINING  
516-767-5975 (Fax 767-5994)

PHYSICAL ACTIVITY MODIFICATION FORM

Patient \_\_\_\_\_ Injury/Condition \_\_\_\_\_ Date \_\_\_\_\_

Grade \_\_\_\_\_ Teacher/Coach \_\_\_\_\_ Class/Sport \_\_\_\_\_

Dear Doctor \_\_\_\_\_,

- All students attending schools in New York State are required to attend physical education classes.
- These classes must be adapted if the student has medical limitations.
- If a student is unable to participate fully in the physical education program they must have activities modified to meet their individual needs.
- Additionally, a student-athlete who participates in the school athletic program, who has sustained an injury or illness removing them from sports, will have an opportunity to participate in alternative activities to maintain their fitness.

The above named student has indicated an inability to participate fully in the regular Physical Education / Athletic program. So that you may assist us in designing a program adapted to meet his/her needs, please complete this form and return it to the school Medical Office.

If you have any questions or concerns, you may contact the school at the above numbers.

Thank you for your cooperation.

Please **CHECK** those activities where **PARTICIPATION IS RECOMMENDED**:

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Running         | <input type="checkbox"/> Yoga              | <input type="checkbox"/> Weight Training | <input type="checkbox"/> Collision Contact Sports<br>(i.e. football, lacrosse, hockey) |
| <input type="checkbox"/> Walking         | <input type="checkbox"/> Bending/Twisting  | <input type="checkbox"/> Upper Body      |  |
| <input type="checkbox"/> Jumping         | <input type="checkbox"/> Stretching        | <input type="checkbox"/> Lower Body      |  |
| <input type="checkbox"/> Tumbling        | <input type="checkbox"/> Catching          | <input type="checkbox"/> Cardiovascular  | <input type="checkbox"/> Contact Sports<br>(i.e. soccer, basketball, wrestling)        |
| <input type="checkbox"/> Pushing/Pulling | <input type="checkbox"/> Throwing          | <input type="checkbox"/> Bike            |  |
| <input type="checkbox"/> Dancing         | <input type="checkbox"/> Skating           | <input type="checkbox"/> Treadmill       | <input type="checkbox"/> Strenuous Sports<br>(i.e. swimming, track, gymnastics)        |
| <input type="checkbox"/> Outdoors        | <input type="checkbox"/> Cardio Kickboxing | <input type="checkbox"/> Elliptical      | <input type="checkbox"/> Less Strenuous Sports<br>(i.e. bowling, golf)                 |
| <input type="checkbox"/> Climbing        | <input type="checkbox"/> Kicking           | <input type="checkbox"/> Stepper         |  |
| <input type="checkbox"/> High Ropes      | <input type="checkbox"/> Punching          |  | <input type="checkbox"/> Other   |
|  |  |  | <input type="checkbox"/> Elevator  |

I also recommend the following exercises and/or activities to assist the student's recovery:

I have examined the above named patient and recommend that his/her Physical Education / Athletic program be modified as above until \_\_\_\_\_ (date).

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Office Stamp Required

This document will become part of the student's health record. The information on it will be provided to those individuals who require it for the student's instruction and care. No other release will be made.