

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 than 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:
<input type="checkbox"/> Skills requiring student to an inverted position, bearing weight on head or neck (i.e. forward/backward roll, tripod, headstand)
<input type="checkbox"/> Skills requiring student in an inverted position, without bearing weight on head or neck (i.e. cartwheel, handstand)
<input type="checkbox"/> No inverted positions permitted

Physical Contact
<input type="checkbox"/> Activities in which physical contact is likely to occur (i.e. basketball, soccer, floor hockey)
<input type="checkbox"/> Activities in which incidental physical contact may occur (i.e. structured drill situations, small group games)
<input type="checkbox"/> Individual skill building activities in which physical contact is not likely to occur

Strength Training
<input type="checkbox"/> LOWER body exercises using free weights, weight machines, etc.; with a maximum weight of: _____ lbs.
<input type="checkbox"/> 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)