



Poway Unified School District
15250 Avenue of Science, San Diego CA 92128

Health Services
Physician's Authorization for Physical Education

Student _____ Date _____

Date of Birth _____ School _____ Grade _____

This portion to be completed by a physician licensed in the State of California.

Please provide the following:

1. Specific Diagnosis _____
2. Impairment of locomotion _____
3. Postural, Cardio-vascular, respiratory or glandular condition _____

4. Other disabling physical conditions _____

The student's physical activities will be limited for the following period of time _____

Please check those items in which you **DO NOT** want the student to participate during the school day:

<input type="checkbox"/> Bars	<input type="checkbox"/> Kicking Type Games	<input type="checkbox"/> Straight Leg Lifts
<input type="checkbox"/> Basketball	<input type="checkbox"/> Lacrosse	<input type="checkbox"/> Swimming
<input type="checkbox"/> Catching-type Games	<input type="checkbox"/> Leg Strengthening	<input type="checkbox"/> Swings
<input type="checkbox"/> Contact Sports	<input type="checkbox"/> Lower Back Exercises (Sit-ups, pull-ups)	<input type="checkbox"/> Tennis
<input type="checkbox"/> Cross Country Running	<input type="checkbox"/> Racquetball	<input type="checkbox"/> Tetherball
<input type="checkbox"/> Flexibility/Stretching	<input type="checkbox"/> Running	<input type="checkbox"/> Tumbling/Summersaults
<input type="checkbox"/> Jumping	<input type="checkbox"/> Slide	<input type="checkbox"/> Upper Back Exercises
<input type="checkbox"/> Jogging	<input type="checkbox"/> Soccer	<input type="checkbox"/> Upper Body Movement
<input type="checkbox"/> Gymnastics (vaulting, balance beam)	<input type="checkbox"/> Softball	<input type="checkbox"/> Walking
<input type="checkbox"/> Jump Rope	<input type="checkbox"/> Squatting	<input type="checkbox"/> Wrestling

I recommend the following:

Other restrictions _____

Does this student have a medical condition which necessitates their wearing a helmet? Yes No

If yes, please state for which activities the helmet must be worn (i.e., recess, classroom) _____

Physician's Signature _____ Date _____

Physician's Name (Print) _____ CA Medical License _____

Phone _____ Fax _____

Parent Signature _____ Date _____