CITY SCHOOL DISTRICT OF ALBANY
BUREAU OF HEALTH AND PHYSICAL EDUCATION

ADAPTED PHYSICAL EDUCATION - MEDICAL RECOMMENDATION

SCHOOL _______________________________ DATE _______________________________

TO: Dr. _______________________________

All students registered in schools within New York State are required by New York State Education Law and Regulations to attend courses of instruction in physical education. These courses must be adapted to meet the needs of the individual student when medical limitations exist. This means that a student who is UNABLE TO PARTICIPATE FULLY IN THE ENTIRE PROGRAM MUST HAVE ACTIVITIES MODIFIED TO MEET HIS/HER INDIVIDUAL NEEDS.

Your patient, ______________________________, is registered in the City School District of Albany and has indicated an inability to participate fully in the regular physical education program. So that we may design a program appropriately adapted to meet his/her individual needs, please complete this form and return it to the student's school.

Check the activities listed below in which your patient MAY NOT PARTICIPATE:

☐ Throwing ☐ Bending ☐ Pushing ☐ Tumbling
☐ Catching ☐ Twisting ☐ Pulling ☐ Stretching
☐ Kicking ☐ Hitting ☐ Body Contact ☐ Off the Floor Activities
☐ Running ☐ Walking ☐ Water ☐ Other: ____________
☐ Lifting ☐ Jumping ☐ Out of Doors

Are there any specific exercises or activities that you feel would benefit this student? ☐ NO ☐ YES

If “YES”, please indicate the activities. __________________________________________________________________

_________________________________________________________________________________________________

Additional Physician Remarks: _____________________________________________________________________

This is to certify that I have examined the above patient and recommend that his/her physical education program be modified as indicated above until the following date ________________________.

______________________________________    ______________________________________
Physician’s Name (Print)       Physician’s Signature

______________________________________    ______________________________________
Date         Telephone Number

NOTE: This report will be attached to the student’s health record with duplicates sent to the physical education teacher and the parent/guardian. If you have any questions, please contact the School Nurse/Teacher. Thank you for your cooperation.

________________________________________
Physical Education Teacher

________________________________________
School Nurse/Teacher

________________________________________
School Address

________________________________________
Telephone Number