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

Health Services

Physician's Authorization for Physical Education / Activity Post Injury

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. Please describe impact on physical activity: _____
3. The student's physical activities will be limited for the following period of time: _____
   (Form to be updated annually)

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

☐ Basketball	☐ Kicking	☐ Swimming
☐ Catching-type Games	☐ Lacrosse	☐ Tennis
☐ Contact Sports	☐ Leg Strengthening	☐ Tumbling/Summersaults
☐ Cross Country Running	☐ Lower Back Exercises (Sit-ups, pull-ups)	☐ Upper Back Exercises
☐ Dance	☐ Racquet Sports	☐ Upper Body Movement
☐ Flexibility/Stretching	☐ Running	☐ Walking
☐ Jumping	☐ Soccer	☐ Weight Lifting
☐ Jogging	☐ Softball	☐ Wrestling
☐ Gymnastics (vaulting, balance beam)	☐ Squatting	☐ Yoga
☐ Jump Rope	☐ Straight Leg Lifts	☐ Other
Playground Activity:		
☐ Bars	☐ Swings	☐ Play Structure
☐ Slide	☐ Tetherball	

4. Other restrictions: _____
   _____
5. Does this student have a medical condition which necessitates the use of assistive devices? □ **Yes** □ **No**
   Type of assistive device: □ **Crutches** □ **Helmet** □ **Scooter** □ **Wheelchair**
   □ **Other (i.e. weight bearing limitations):** _____
   Length of time recommended: _____

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

Physician's Signature _____ Date _____

Physician's Name (Print) _____ **CA Medical License** (MD/DO/NP/PA) _____

Phone_____ **Fax**_____

Parent Signature _____ Date _____