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Cape May County Technical High School
188 Crest Haven Road
Cape May Court House, New Jersey 08210
Health Office: (609) 465-2161 ext. 658   FAX: 465-5033

Shop Activity Restrictions and/or Adaptive Physical Education

Student Name:________________________________ Grade:_____ FT/ST Shop assigned: ___________________

The above student is under my care and may participate in the following adaptive physical education and shop program from _____________ to _____________. Diagnosis/Reason:____.

Due to the above named student's physical or mental health condition, a physician must verify that the student is able to work in a shop that involves the use of power tools, hazardous equipment, and the possibility of contact with potentially dangerous substances under supervision. *Please keep in mind the safety of the other students in the class, as the shop is a cooperative working experience designed for employment in the selected shop.*

SHOP RESTRICTIONS? NO YES If "YES", circle what activities are contraindicated, add any other restrictions that may be necessary: No off campus unless medical personnel is available, no climbing ladders/no heights, no working in sun or hot climate, no use of hazardous machinery, no waterway activities, no welding work, no work with saw dust, no work with chemicals or materials that produce fumes or dust, no prolonged computer viewing, no lifting over____pounds, other:____

SPORTS

YES	NO	If some activities are permitted but others are not, cross off any that are not permitted.
____	____	Contact (soccer, basketball, volleyball, baseball, field/floor hockey, handball, football)
____	____	Non-contact (swimming, tennis, ping-pong, badminton, bowling, horseshoes)

CARDIO-RESPIRATORY ENDURANCE

YES	NO	If some activities are permitted but others are not, cross off any that are not permitted
____	____	High impact aerobics (aerobic exercises, running, jumping, step, kick boxing)
____	____	Low impact aerobics (walking, speed walking, stair master)

MUSCULAR/STRENGTH ENDURANCE

YES	NO	If some activities are permitted but others are not, cross off any that are not permitted
____	____	Weight Lifting If permitted, write in any restrictions: (ie.: upper body or lower body work only or weight limitation of ____ pounds): ______________________________
____	____	Stretching Exercises If permitted, write in restrictions: (ie.: no sit ups)____________________

PARENT Name (Print):______________________________ **Signature**:_______________________ **Date**:_______

PHYSICIAN Name (Print):___________________________ **Signature**:_______________________ **Date**:_______

Physician's Address:____ **Physician's Telephone**: _________________

NURSE COPY TO: FILE ____ /____/____ PE ____/____/____ Guidance Counselor ___/____/____

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