Physical Education and Shop Restriction Form

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

The above student is under my care and may participate in the following <u>adaptive</u> 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 vocation that involves the use of power tools, hazardous equipment, and the possibility of contact with potentially dangerous substances or environments under general adult supervision.
Please, keep in mind the safety of the other students, *as the shop/vocational placement is a cooperative working experience designed for employment in the selected vocation/shop.*

SHOP/VOCATIONAL/WORK RESTRICTIONS:

☐ NO RESTRICTIONS -There are NO restrictions relevant to this student's safety or the safety of other students.
☐ Not permitted off the school's main campus unless medical personnel is available
☐ No climbing ladders/No heights   ☐ No working in sun/hot climate/cold temperatures   ☐ No hazardous machinery
☐ Risk of drowning due to medical condition:
　　☐ No waterway activities or ☐ Caution (always have life vest and adult "buddy" with student)
☐ 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 restrictions:_____

PHYSICAL EDUCATION CLASSES AND SPORTS:

Check off: PERMITTED ACTIVITIES

Contact strenuous: ☐soccer ☐basketball ☐volleyball ☐softball ☐field/floor hockey ☐handball ☐flag football

Non-contact: ☐ tennis ☐ ping-pong ☐ badminton ☐ bowling ☐ horseshoes ☐ archery

High impact aerobics: ☐ aerobic exercises ☐ running ☐ jogging ☐ jumping ☐ step ☐ kick boxing

Low impact aerobics: ☐ walking   ☐ speed walking ☐stair master

Weight Lifting: ☐ upper body ☐ lower body   ☐ Weight limitation of ____ pounds

Fitness routine: ☐ stretching   ☐ sit-ups ☐ push-ups ☐ pull-ups   ☐Other:
_____

Other comments: _____

PHYSICIAN Name (Print):_____ **Signature**:_____ **Date**:_____

Physician's Address:_____ **Physician's Telephone**: _____

NURSE COPY TO: PE ____/____/____   Guidance Counselor ___/____/____   lz:CAREPLAN\PE and Shop Restrictions 2013