

**Bay Shore Union Free School District**  
**Department of Health, Physical Education and Athletics**  
75 West Perkal Street  
Bay Shore, New York 11706

**SPORT:** \_\_\_\_\_  
**Grade:** \_\_\_\_\_

**Physical Education Medical Recommendation Form For Bay Shore High School**

**To: Dr.** \_\_\_\_\_ **Date** \_\_\_\_\_

**Name:** \_\_\_\_\_ **Sex:** \_\_\_\_\_ **Diagnosis:** \_\_\_\_\_

Your patient is registered in this school district and has indicated a health history which may limit his/her ability to participate fully in the regular Physical Education program. Kindly complete this form and return it to his/her school. Thank you for your cooperation. If you have any questions, please call

High School.....Mrs. Mason, RN at (631) 968-1166 Fax (631) 968-2581

**IMPORTANT: Any student excused from Physical Education will be required to make up all missed classes to receive credit for graduation. Therefore, we encourage PE modification if possible.**

**NO RESTRICTIONS - CLEARED FOR P E & SPORTS**

**CLEARED FOR P E ONLY**

**NO P E / SPORTS UNTIL \_\_\_\_\_**  
**DATE**

**MODIFIED P E**

**Check only where NO PARTICIPATION IS RECOMMENDED IN ACTIVITIES INVOLVING:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> running         | <input type="checkbox"/> body contact       | <input type="checkbox"/> cybex machine   |
| <input type="checkbox"/> lifting         | <input type="checkbox"/> outside activities | <input type="checkbox"/> treadmill       |
| <input type="checkbox"/> walking         | <input type="checkbox"/> hanging            | <input type="checkbox"/> rowing machine  |
| <input type="checkbox"/> stretching      | <input type="checkbox"/> climbing           | <input type="checkbox"/> stationary bike |
| <input type="checkbox"/> upper body only | <input type="checkbox"/> weight training    | <input type="checkbox"/> other           |
| <input type="checkbox"/> lower body only |   |  |

**This is to certify that I have examined the above patient and recommended that his/her physical education program be modified according to the information above until \_\_\_\_\_.**  
**Date**

**Additional PhysiciansRemarks:** \_\_\_\_\_

\_\_\_\_\_  
**Physician's Signature** **Date**

**PHYSICIAN'S STAMP**

