



**SAN MATEO UNION HIGH SCHOOL DISTRICT**

**PHYSICAL EDUCATION MEDICAL EXEMPT FORM**

School name: \_\_\_\_\_

School address: \_\_\_\_\_

<b>PART 1: TO BE COMPLETED BY THE PARENT/GUARDIAN</b>	
Student Name:	Date:
Address:	Home Phone:
School:	DOB:
Physician's Name:	Phone:
I give my permission to the SMUHSD to confidentially and discreetly use the content of this form to plan my student's Physical Education Program.	
Parent/Guardian Signature:	Date:

<b>PART 2: TO BE COMPLETED BY THE PHYSICIAN</b>	
Medical diagnosis:	
Duration of the condition is: <ul style="list-style-type: none"> <li>• Short Term</li> <li>• Long Term</li> <li>• Permanent</li> </ul>	The condition is: <ul style="list-style-type: none"> <li>• Progressive</li> <li>• Non-progressive</li> </ul>
Date student may return to unrestricted activity:	Date student will be reexamined:
Functional capacity: <ul style="list-style-type: none"> <li>• Unrestricted (no restriction on contact or intensity)</li> <li>• Mild restriction (only avoid vigorous activities)</li> <li>• Moderate restriction (limits sustained, strenuous activities)</li> <li>• Severe restriction (limits are severe)</li> </ul>	

**PART 3: TO BE COMPLETED BY THE PHYSICIAN**

Check all activities that you consider to be appropriate for the student to participate in. Remember all activities will be modified for student's ability level.

- Step Aerobics
- Power walk (4 min laps)
- Running (jogging/sprinting)
- Swimming
- Curl Ups
- Free Weights (light)
- Pull Ups
- Weight Machines
- Push Ups
- Individual sports/games
- Team sports/games
- Tumbling

**Additional recommendations for modification?**

**Signature of Authorized Health Care Provider:**

\_\_\_\_\_

**Date:** \_\_\_\_\_

**Health Care Provider Address Stamp (required):**

**This form is to be turned in to the school Health Office.**