Northside Independent School District

Dear Parent,

All students enrolled in Northside Independent School District are required to take a designated amount of physical education at each grade level. A student will be assigned to a restricted physical education program when it is possible to accommodate the student's physical limitations by modifying the activities of a regular physical education program. A "restricted" physical education program is taught by a "regular" physical education teacher, usually as part of a regular physical education class.

In order for school personnel to plan accordingly for the individual needs of your child, please ask your physician to complete the attached form and return as soon as possible.

Sincerely,

David Halbert

David Halbert
Instructional Specialist K-12
Physical Education
Curriculum and Instruction
Northside Independent School District
Office (210) 397-8144
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NORTHSIDE ISD RESTRICTED PHYSICAL EDUCATION FORM

Dear Physician,

All students in the State of Texas are required to take a designated amount of physical education at each grade level. Students in 3rd – 12th grade must also be assessed on their physical fitness using the state-approved FITNESSGRAM assessment. A student who is unable to participate without restrictions in the general or adapted physical education program due to a specific physical condition will have his/her program modified based on the results of this document.

Student Name: _____ Date of Birth: _____ Age: _____

School: _____ Grade: _____ Student ID#: _____

Parent Name: _____ Phone: _____ Email: _____

MEDICAL INFORMATION

Primary Disability: _____

Secondary Disability: _____

Brief description of the medical condition as it relates to participation in general physical education

activities: _____

_____

_____

Heart Disease/defect/high blood pressure	☐ Yes	☐ No	
Seizures/Epilepsy	☐ Yes	☐ No	
Diabetes	☐ Yes	☐ No	Type: _____
Visual Impaired	☐ Yes	☐ No	
Deaf or Hard of Hearing	☐ Yes	☐ No	
Serious Bone or joint disorder	☐ Yes	☐ No	
Scoliosis	☐ Yes	☐ No	
Shunt	☐ Yes	☐ No	
G-Tube	☐ Yes	☐ No	
VNS	☐ Yes	☐ No	
Asthma	☐ Yes	☐ No	Asthma plan date: _____
Down Syndrome	☐ Yes	☐ No	
Have cervical spine x-rays been done?	☐ Yes	☐ No	If yes, Date: _____
Atlantoaxial Instability?	☐ Yes	☐ No	

Allergies to the following:

☐ Medicines List: _____

☐ Foods List: _____

☐ Insect stings/bites List: _____

Please check the appropriate activity levels

General Precautions	Unrestricted (Not Limited)	Restricted (circle one)	Adapted and Remedial	If Adapted/Remedial, specify:
Weight-bearing Activities	☐	Permanent Temporary	☐	☐ Limit to ____ lbs; ☐ Partial weight-bearing on ____ limb; ☐ Non-weight-bearing; ☐ Other/Comments: _____
Sudden movements/ Changes	☐	Permanent Temporary	☐	☐ Gradual transitions; ☐ Avoid rapid changes in direction; ☐ Other/Comments: _____
Cardiovascular Endurance/Prolonged Activity	☐	Permanent Temporary	☐	☐ Requires breaks every ____ minutes; ☐ Limit to ____ minutes; ☐ Other/Comments: _____
Lifting/Carrying	☐	Permanent Temporary	☐	☐ Weight limit: ____ lbs; ☐ Proper lifting techniques required; ☐ Other/Comments: _____
Overhead Activities	☐	Permanent Temporary	☐	☐ Limit range of motion to ____ degrees; ☐ Avoid sustained overhead reaching; ☐ Other/Comments: _____
Flexibility/Stretching Movements	☐	Permanent Temporary	☐	☐ Limit trunk rotation to ____ degrees; ☐ Avoid twisting under load; ☐ Other/Comments: _____
Extreme Temperatures	☐	Permanent Temporary	☐	☐ Avoid temperatures above/below ____ °F; ☐ Requires frequent breaks in heat/cold; ☐ Other/Comments: _____

General Movements	Unrestricted (Not Limited)	Restricted (circle one)	Adapted and Remedial	If Adapted/Remedial, specify:
Locomotion (walking, running, jumping, etc.)	☐	Permanent Temporary	☐	☐ Walking only; ☐ Limit distance to _____; ☐ No jumping down from objects; ☐ Other/Comments: _____
Object Manipulation (balls, bean bags, frisbees, etc.)	☐	Permanent Temporary	☐	☐ Use modified equipment (specify below); ☐ Limit throwing distance/force; ☐ Other/Comments: _____

Please check the appropriate activity levels

General Movements	Unrestricted (Not Limited)	Restricted (circle one)	Adapted and Remedial	If Adapted/Remedial, specify:
Static/Dynamic Balance	☐	Permanent Temporary	☐	☐ Requires Support: ☐ Static ☐ Dynamic; ☐ Avoid single-leg stance; ☐ Other/Comments: _____
Large Group Activities/Team Sports (Volleyball, basketball, soccer, football, etc.)	☐	Permanent Temporary	☐	☐ Modified rules/participation (specify below); ☐ Specific safe positions only (specify below); ☐ Sport/Game skills but no contact: ☐ Other/Comments: _____
Individual Sports/Act.	☐	Permanent Temporary	☐	☐ Specific sport/activity modifications (specify below) ☐ Other/Comments: _____

Sport Skills	Unrestricted (Not Limited)	Restricted Permanent	Adapted and Remedial	If Adapted/Remedial, specify:
Catching	☐	☐	☐	☐ Use modified equipment (specify below); ☐ Shorter distances; ☐ Other/Comments: _____
Throwing	☐	☐	☐	☐ Use modified equipment (specify below); ☐ Limit throwing distance/force; ☐ Other/Comments: _____
Hand Dribbling	☐	☐	☐	☐ Use modified equipment (specify below); ☐Other/Comments: _____
Kicking	☐	☐	☐	☐ Use modified equipment (specify below); ☐ Limit kicking distance/force; ☐ Other/Comments: _____
Striking/Volleying	☐	☐	☐	☐ Use modified equipment (specify below); ☐ Other/Comments: _____
Pushing/Rolling	☐	☐	☐	☐ Limit to ____ lbs; ☐ Limit pushing distance/force; ☐ Other/Comments: _____
Pulling	☐	☐	☐	☐ Limit to ____ lbs; ☐ Other/Comments: _____

Please check the appropriate activity levels

Physical Fitness Assessment Health Classifications

Unrestricted: This classification indicates no physical limitations that would affect an individual's full involvement in physical activities.

Restricted Permanent: This classification means permanent physical activity restrictions due to a medical impairment. These limitations are not expected to change.

Restricted Temporary: This classification signifies temporary restrictions on physical activity. The impairments are expected to recover, and the limitations are not permanent.

Adapted and Remedial: This classification applies when accommodations or modifications are required for an individual to participate safely and effectively in FitnessGram activities.

FitnessGram (Grades 3-10)	Unrestricted	Restricted Permanent	Restricted Temporary	Adapted and Remedial
BMI	☐	☐	☐	☐
PACER (Progressive Aerobic Cardiovascular Endurance Run)	☐	☐	☐	☐
Curl Up. (Muscular Strength and Endurance test)	☐	☐	☐	☐
Trunk Lift (Flexibility)	☐	☐	☐	☐
Push-Up (Muscular Strength and Endurance test)	☐	☐	☐	☐
Sit & Reach (Flexibility)	☐	☐	☐	☐

PHYSICIANS RECOMMENDATION:
These restrictions are recommended until: _____

Additional Comments: _____

_____

Physician's Name (Print): _____

Address: _____ City: _____ State: ____ ZIP: _____

Phone Number: _____

Physicians Signature: _____ Date: _____