MINEOLA SCHOOL DISTRICT
MINEOLA, NEW YORK
PHYSICIAN'S RECOMMENDATION FOR PHYSICAL ACTIVITY (PRE- K - 5)

Name: _____D.O.B: _____

Address: _____ Phone: _____

School: _____ Grade: _____ Date: _____
This is to certify that I have examined the above student and find the following abnormal condition:_____

_____

The student _____ be using crutches? This _____ considered a
will/will not *is/is not*
handicap condition? This condition is _____.
Permanent/Temporary

This certifies that the above named student is physically qualified to participate in the following categories.

ACTIVITIES Pre-K - 5

Locomotive Fundamental Movements		**Non Locomotive Fundamental Movements**		**Manipulative Skills**		**Rhythmic Movement**	
Walking	Y/N	Bending	Y/N	Catching	Y/N	Dancing	Y/N
Walking Briskly	Y/N	Rocking/ Swaying	Y/N	Throwing	Y/N	See	
Running	Y/N	Swinging	Y/N	Kicking	Y/N	"Locomotive	
Sprinting	Y/N	Turning	Y/N	Hitting	Y/N	Fundamental	
Hopping	Y/N	Twisting	Y/N	Bouncing/Ball	Y/N	Movements"	
Skipping	Y/N	Stretching	Y/N	Rope Jumping	Y/N		
Gliding	Y/N	Pushing/Object	Y/N	Scooters	Y/N		
Galloping	Y/N	Pulling/Object	Y/N				
Leaping	Y/N						
Fitness Activities		**Apparatus Activities**		**Sports**		**Recess**	
Stretching	Y/N	Rope Climbing	Y/N	Baseball	Y/N	Swings	Y/N
Pushups	Y/N	Balance Beam	Y/N	Football	Y/N	Climbing Apparatus	Y/N
Sit-ups	Y/N	Hoops	Y/N	Hockey	Y/N	Monkey Bars	Y/N
Jogging	Y/N	Jumping Robe	Y/N	Basketball	Y/N		
Jumping Jacks	Y/N	Balance Board	Y/N	Tennis	Y/N		
Aerobics	Y/N	MATS:		Soccer	Y/N		
		Log Rolls	Y/N	Volleyball	Y/N		
		Forward Rolls	Y/N	Kickball	Y/N		
		Backward Rolls	Y/N				
		Tip-ups	Y/N				
		Animal Movements	Y/N				

Student should return for re-examination on _____. Student may return to unrestricted activity on _____.

_____
Physician's Name/Signature *Date*

_____
Physician's Address *Phone*

(21. 7/03)