

SACHEM MIDDLE SCHOOLS PHYSICAL EDUCATION ACTIVITY FORM

TO: Dr. _____ Date: _____

RE: _____
Name of Student
Grade

All pupils registered in a school in New York State are required by the Education Law to attend courses of instruction in Physical Education. These courses will be adapted to meet individual pupil needs when possible. This means that a pupil who is unable to participate in the entire program may have his/her activities modified to meet his/her needs and/or improve his/her condition. The Physical Education classes are approximately 40 minutes in length and are held three times per week.

The following is a general list of activities included in the Middle School Physical Education program:

PLEASE CHECK THE ACTIVITIES IN WHICH THIS PUPIL MAY PARTICIPATE.

- | | | |
|--|--|--|
| <input type="checkbox"/> Adventure games
<input type="checkbox"/> Aerobics
<input type="checkbox"/> Step <input type="checkbox"/> Low-Impact <input type="checkbox"/> Tae Bo
<input type="checkbox"/> Badminton
<input type="checkbox"/> Basketball
<input type="checkbox"/> Cardio – Fitness
<input type="checkbox"/> Elliptical
<input type="checkbox"/> Glid | <input type="checkbox"/> Dance
<input type="checkbox"/> European Handball
<input type="checkbox"/> Field Hockey
<input type="checkbox"/> Flag/touch Football
<input type="checkbox"/> Floor Hockey
<input type="checkbox"/> Lacrosse – non-contact
<input type="checkbox"/> Long Distance/Mile Run | <input type="checkbox"/> Softball
<input type="checkbox"/> Table Tennis (Spec. Ed.)
<input type="checkbox"/> Team Handball
<input type="checkbox"/> Track & Field
<input type="checkbox"/> Volleyball
<input type="checkbox"/> Walking
<input type="checkbox"/> Weight Training Only |
|--|--|--|

This is to certify that I have examined the ab

_____ and recommend that he/she should
 participate only in the activities that are checked for a period of _____ weeks. When do you wish the patient to return to
 you for re-evaluation? _____ When may student return to full P.E.? _____
DATE
DATE

Additional Remarks: _____

 Physician's Signature

 Address

Please return to **School Nurse**