ROCKLIN HIGH SCHOOL PHYSICAL EDUCATION
5301 Victory Lane, Rocklin CA 95765 (916) 632-1600 Ex. 6194 Fax(916) 632-0305

Dear Physician:

The Rocklin High School Physical Education Department would like to work with you to find the correct placement for your patient in our curriculum. Please use the attached form as a reference for our staff to consider when meeting the needs of this student.

- **MODIFIED Physical Education:**
  Would allow the student to participate in Physical Education with some minor modifications to the regular requirements of the RUSD Physical Education curriculum. MPE will address motor and skill development, as well as physical fitness. MPE is designed to accommodate students who have short-term injuries, recent surgery, or chronic conditions such as asthma, scoloiosis, etc…Physical Education credits will be given in accordance with the standards as stated in the Physical Education Handbook. A short term injury is defined as one that would eliminate the student from Physical Education for LESS than 6 weeks.
- **Physical Education EXEMPTION:**
  Would NOT allow the student to participate or continue in Physical Education. This student has a severe disability, long term injury, or physical limitation due to injury or medical condition which requires elimination from Physical Education for MORE than 6 weeks. Physical Education credits will not be given. Referrals will be reviews each semester for all Physical Education exemptions.

Thank you for your help and cooperation-
Sincerely,

Steve Taylor, Physical Education Department Chair
staylor@rocklin.k12.ca.us
Dave Muscarella
Debi DeVinna
Jason Adams
Grant Depue

PE TEACHER_____
Period: _____

ROCKLIN HIGH SCHOOL PHYSICAL EDUCATION DEPARTMENT

Release of Medical Information FAX (916) 632-0305

CONFIDENTIAL

PARENT RELEASE:

Student Name: _____ Age: _____ Grade: 9 10 11 12

Address: _____

Parent/Guardian Name (Print): _____ Signature: _____

Home Phone: _____ Mother's work phone : _____Father's work phone : _____

Doctor's Name: _____ Phone: _____

For Physician Use Only

1. Diagnosis: Please include type and extent of injury/illness/chronic condition and make recommendations pertaining to each type (i.e. asthma, sprain, fracture, postural deviation, cardiac/vision/hearing..)

_____

_____

_____

2. Please indicate body areas in which activity should be modified/limited/eliminated.

_____

_____

3. Please provide activity recommendations for student's participation in Physical Education

General Conditioning	OMIT	Modify	No Restrictions	**SPECIFIC Activities**	OMIT	Modify	No Restrictions
Core Exercises				Swimming			
Upper Body				Volleyball/Tennis			
Stretching				Basketball/Soccer			
Jumping				Weight Lifting			
Power Walking				Dance			
Jogging/Running **time or distance**				Other			

Comments: _____ ☐ _____

_____

This student qualifies for: Modified Physical Education length of time: _____

☐ Exemption from Physical Education length of time: _____

Doctor's Signature: _____ Date: _____

For School Use:

Verification by Nurse:

Comments: _____

Nurse Signature: _____ Date: _____

Principals Signature: _____ Date: _____