Last Name (print) _____ First Name (print) _____

DOLGEVILLE CENTRAL SCHOOL
Physician's Documentation for Physical Activity Restrictions

To Be Completed by Student-Athlete's Physician or Emergency Room Physician Following Illness or Injury and Returned to the School Health Office

**Note: If the student-athlete has sustained a head injury or concussion, the school and physician must follow the District's concussion protocol. The protocol is available at www.dolgeville.org.*

Name of Student: _____ DOB: _____ / _____ / _____

Due to illness or injury, the above-named student has the following restrictions on physical activity:

☐ Complete Physical Activity Restriction: The student may NOT participate in ANY forms of physical activity.

Effective Dates: From _____ / _____ / _____ to _____ / _____ / _____

☐ Limited Physical Activity Restriction: The student MAY participate in the following forms of physical activity:

- ☐ Lower body exercises - Examples: walking, treadmill, stationary bike, step machine, lower body weights
- ☐ Upper body exercises - Example: upper body weights
- ☐ Full body low-impact exercises - Example: Pilates, yoga, core workouts
- ☐ Non-contact sports – Examples: badminton, ping pong, bocce ball, tennis, golf

Effective Dates: From _____ / _____ / _____ to _____ / _____ / _____

☐ No Physical Activity Restrictions: The student has no restrictions and may participate in all forms of physical activity.

Physician's Signature: _____ Date: _____ / _____ / _____

This document is to be completed by the student's physician and kept on file at Dolgeville Central School in accordance with New York State physical education regulations.