

**CHENANGO VALLEY CENTRAL SCHOOL DISTRICT**  
**MODIFIED/MEDICAL PHYSICAL EDUCATION FORM**

To: \_\_\_\_\_ Date: \_\_\_\_\_  
Regarding the physical education activities of your patient, \_\_\_\_\_ DOB \_\_\_\_\_

We appreciate your cooperation in filling out this form and returning it as soon as possible to:  
**Amy Frost, RN, or Kim Riquier, RN at 221 Chenango Bridge Road, Binghamton, NY 13901, or**  
**Fax to 762-6897**

**In New York State all students are required by education law to attend courses of instruction in physical education. This means that pupils who are unable to participate in the entire program should have their activities modified to meet their needs.**

**Please check (x) individually the type of physical activity you recommend for this student.**

**CONTACT COLLISION**

- |  |                                   |
|--|-----------------------------------|
| <input type="checkbox"/> Field Hockey  | <input type="checkbox"/> Soccer   |
| <input type="checkbox"/> Wrestling     | <input type="checkbox"/> Lacrosse |
| <input type="checkbox"/> Mountain Bike | <input type="checkbox"/> Football |

**LIMITED CONTACT / IMPACT**

- |  |   |                                       |
|--|---|---------------------------------------|
| <input type="checkbox"/> Baseball / Softball | <input type="checkbox"/> Volleyball           | <input type="checkbox"/> Kickball     |
| <input type="checkbox"/> Basketball          | <input type="checkbox"/> Ultimate Frisbee     | <input type="checkbox"/> Whiffle Ball |
| <input type="checkbox"/> Diving              | <input type="checkbox"/> Jump Rope Activities |                                       |

**STRENUOUS – NON CONTACT**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Cross Country Running | <input type="checkbox"/> Dance, Dance Revolution   | <input type="checkbox"/> Aerobics      |
| <input type="checkbox"/> Cross Country Skiing  | <input type="checkbox"/> Pilates                   | <input type="checkbox"/> Taebo         |
| <input type="checkbox"/> Track and Field       | <input type="checkbox"/> Zumba                     | <input type="checkbox"/> Pickle ball   |
| <input type="checkbox"/> Swimming              | <input type="checkbox"/> Square Dance / Line Dance | <input type="checkbox"/> Rockwall      |
| <input type="checkbox"/> Tennis                | <input type="checkbox"/> Treadmill                 | - Climbing                             |
| <input type="checkbox"/> Badminton             | <input type="checkbox"/> Paddleball                | - Belaying                             |
| <input type="checkbox"/> Racquetball           | <input type="checkbox"/> Weight Training           |  |
| <input type="checkbox"/> Fitness Gram          | - Weight Lifting                                   | <input type="checkbox"/> Exercise Bike |
| - Curl Ups                                     | - Push Ups   |  |
| - Sit and Reach                                | - Light Weight Rebuilding                          |  |
| - Walk/Run Mile                                |  |  |

**NON-STRENUOUS / NON-CONTACT**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Bowling        | <input type="checkbox"/> Swimming – Therapeutic    | <input type="checkbox"/> Walking            |
| <input type="checkbox"/> Golf           | <input type="checkbox"/> Orienteering / Geocaching | <input type="checkbox"/> Bocce Ball         |
| <input type="checkbox"/> Miniature Golf | <input type="checkbox"/> Ping Pong                 | <input type="checkbox"/> Yoga               |
| <input type="checkbox"/> Croquet        | <input type="checkbox"/> Officiating               | <input type="checkbox"/> Recreational Games |
|   |  | - Washers                                   |
|   |  | - Bean Bag Toss                             |

**( ) NO PHYSICAL ACTIVITY - knowledge aspect written/typed research only.**

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This is to certify that I have examined \_\_\_\_\_ and recommend that he/she should participate only in the activities that are checked for a period of \_\_\_\_\_ weeks.

Dx: \_\_\_\_\_ Remarks: \_\_\_\_\_

Physician: \_\_\_\_\_ Date: \_\_\_\_\_