OCONOMOWOC AREA SCHOOL DISTRICT

EMPOWERING A COMMUNITY OF LEARNERS AND LEADERS

Pre-Participation PE Plan

District Nurse Phone: 262-560-2104
District Nurse Fax: 262-560-2106

Name	_____	School Year	_____
Birthdate	_____	School	_____
Practitioner	_____	Grade	_____
Practitioner Phone	_____	Practitioner Fax	_____

☐ There are no longer any physical restrictions for my child. (Please sign and return Care Plan)

HEALTH INFORMATION HISTORY: (please circle if more than one choice)

[ ] Yes	[ ] No	Downs Syndrome
[ ] Yes	[ ] No	If yes, has physician examined and x-rayed for Atlantoaxial instability?
		Date of x-ray:_____
[ ] Yes	[ ] No	Blood Pressure Irregularity: high or low
[ ] Yes	[ ] No	Congenital Heart Disease
[ ] Yes	[ ] No	Heart Murmur
[ ] Yes	[ ] No	Extra Heart Beats
[ ] Yes	[ ] No	Cerebral Palsy; Low Muscle Tone, Muscular Dystrophy, Spina Bifida
[ ] Yes	[ ] No	Spinal fusion
[ ] Yes	[ ] No	Bone or joint problems (i.e ankle, Legg Perthes (hip), Osgood Schlatter (knee), Scoliosis)
[ ] Yes	[ ] No	Head injury – history of concussion
[ ] Yes	[ ] No	Convulsive Disorder (seizures)
[ ] Yes	[ ] No	Asthma
[ ] Yes	[ ] No	Loss of function to one eye
[ ] Yes	[ ] No	Kidney Problems or Loss of Function in one kidney, Neurogenic Bladder
[ ] Yes	[ ] No	Medications
		If yes, list type/dosage/when needed:_____
[ ] Yes	[ ] No	Allergies
		If yes, list allergies:_____

I hereby certify that the above named student has been examined and **MAY NOT** participate in the following Phy Ed activities: **(please check all that apply):**

MILD	**MODERATE**	**STRENUOUS**	**STRENUOUS cont.**
[ ] Archery	[ ] Walking, brisk	[ ] Tennis	[ ]Wrestling
[ ] Badminton skills	[ ] Badminton	[ ] Basketball	[ ]Handball
[ ] Walking	[ ] Moderate Exercise	[ ] Calisthenics	[ ]Step Aerobics
[ ] Shoot free throws	[ ] Running	[ ] Soccer (indoor/outdoor)	[ ]Tae Bo
[ ] Table tennis	[ ] Jumping	[ ] Lacrosse	[ ]All of the above
[ ] Horseshoes	[ ] Shoot baskets	[ ] Volleyball	
[ ] Shuffleboard	[ ] Fencing	[ ] Softball/Baseball	
[ ] Frisbees	[ ] Stationary Bike	[ ] Weight lifting	
[ ] Bowling	[ ] Volleyball skills	[ ] Gymnastics	
[ ] Relaxation	[ ] Punching bag	[ ] Floor Tumbling	
[ ] Yoga	[ ] Creative dance	[ ] Flag football	
[ ] Golf	[ ] Inline skating	[ ] Floor hockey	
	[ ] Roller skating	[ ] Track	

Other activity restrictions:_____

Parent/Guardian Signature **Date** **Practitioner Signature** **Date**

By signing this form, I allow the above named practitioner /office) to send by electronic transmission this form to the Oconomowoc Area School District for the purpose of continuing health care at school.