



**Santa Barbara Unified School District
PHYSICAL EDUCATION MEDICAL EXEMPTION APPROVAL FORM**

School name: _____

School address: _____

Signature, Principal *Date*

Part I: TO BE COMPLETED BY THE PARENT/GUARDIAN

Student name: _____ Date: _____

Address: _____ Home phone: _____

School: _____ Date of birth: _____

Physician's name: _____ Phone: _____

I give my permission to the Santa Barbara Unified School District to contact the health care provider and confidentially and discreetly use the content of this form to plan my child's Physical Education Program.

Signature, Parent/Guardian *Date*

Part II: TO BE COMPLETED BY THE HEALTH CARE PROVIDER

Medical diagnosis: _____

Duration of the condition: Short term Long term Permanent
The condition is: Progressive Non-progressive

Date student may return to unrestricted activity: _____

Date student will be reexamined: _____

Functional capacity (Please check one and complete form on the other side)

- Unrestricted (No restriction on contact or intensity)
- Self-limited (Student is able to determine appropriate activities)
- Mild restriction (Only avoid vigorous activities)
- Moderate restriction (Limits sustained, strenuous activities)
- Severe restriction (Limits are severe)

Continued on back

