



2018-2019 SY
Date Rec'd : _____

Madonna Learning Center

Health Information for Participation in PE, OT, and Dance/Movement

Student Name _____

Date of Birth _____

Parent
Name(s) _____

Contact information -

Address: _____

Email address: _____

Cell phone: _____ Home Phone: _____

Cell phone: _____ Other Phone: _____

Please complete the following information in detail, use the back of the form or additional paper as needed. This form must be updated and on file each school year to participate in Physical Education, Occupational Therapy and Dance/Movement Classes.

Does your child have a heart condition? If so, please describe. Will physical activity affect this condition?

Is your child prone to seizures? If so explain necessary precautions.

Does your child have diabetes? If so, how is it treated and how will physical activity affect this condition?

Down Syndrome:

It is recommended that individuals with Down Syndrome have cervical X-rays to detect the presence or absences of Atlanto-Axial Stability. Has your child had X-rays, if so, when and what was determined?

Does your child have any spinal problems and/or has your child had spinal surgery? If yes, please describe. Please include if your child has had or is undergoing physical therapy for this condition. Does your child have a recommended exercise program from a physical therapist? If so, please include a description of the recommended exercises. Is he/she continuing to do the prescribed exercise routine?

Does your child have any bone/joint issues including areas of shoulders, hips, knees, ankles, feet, etc.? If yes, please describe. Please include if your child has had or is undergoing physical therapy for this condition. Does your child have a recommended exercise program from a physical therapist? If so please include a description of the recommended exercises. Is he/she continuing to do the prescribed exercise routine?

Has your child had any surgeries that would affect their mobility? If so, please describe.

Are there any surgeries scheduled or anticipated for the future?

Does your child have vision problems? Does he/she wear glasses? If so, please describe why your child needs glasses (i.e. nearsighted, farsighted, etc) Are the glasses needed during movement activities?

Does your child have any restrictions to participate in PE, Yoga or Dance at this time?

What are your personal goals for your child's functional skills?

What are your personal goals for your child's fitness skills?

Does your child participate in an exercise program or sports activities outside of school? If so what are these activities?

Thank you for providing us with this information. If any of the above changes, please let us know immediately.



Madonna Learning Center

**7007 Poplar Avenue
Germantown, TN 38138**

2018-2019 SY
Date Rec'd : _____

Your patient, _____, attends Madonna Learning Center where classes are offered in PE, Yoga, and Dance/Movement. Kindly confirm whether you approve of your patient's participation in these activities and/or whether you recommend any limitations in any of the above activities.

_____ This patient may participate in PE, Yoga and Dance/Movement activities without restrictions.

_____ This patient may participate in PE, Yoga, and Dance/Movement with the following restrictions:

Physician's Signature _____

Print Physician's Name _____

Physician's Address _____

Physician's Phone Number _____

Dated: _____