בית הספר התיכון של הישיבה דפלטבוש
על שם מר יואל ברברמן
YESHIVAH OF FLATBUSH
JOEL BRAVERMAN HIGH SCHOOL
AL & SONNY GINDI CAMPUS
1609 AVENUE J • BROOKLYN, NY 11230
(718) 377-1100 • FAX: (718) 258-0933

DEPARTMENT OF ATHLETICS & PHYSICAL EDUCATION

ERIC M. AMKRAUT
Athletic Director

re: Medical Restriction from Physical Education

Dear Students/Parents:

The administration of the Yeshivah of Flatbush Joel Braverman High School has revised and implemented a new curriculum for the school's Physical Education program. As such, it is imperative that all students be able to participate to their fullest each and every class period.

Students who cannot physically perform in any given class period are still required to be in attendance and are responsible for all material presented in class. Further, supplemental work may be assigned for those unable to even partially participate in the daily lesson.

If a student is unable to actively participate in class for medical reasons, we are requiring that the attached form be filled out by the student's physician in full. The form will better identify for the school the nature of the student's physical condition as well as the specific limitations placed on him or her and the duration of such restrictions. This form is in addition to any hand-written note provided by a parent or physician. This is important, as the teaching staff will be able to modify lessons for such students so as to accommodate the limitations whenever possible.

Thank you in advance for your understanding and compliance in this matter.

B'shalom,

Eric Amkraut
Atheltic Director/Supervisor of Physical Education

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MEDICAL RESTRICTION FORM

To the Health Care Provider: Please complete both pages, indicating the diagnosis and all related restrictions of activity or function, then sign and date the form. If possible, please indicate the duration of the restriction noting at which point the student can return to full activity.

STUDENT'S NAME: _____

LAST 4 DIGITS OF SSN: _____

DIAGNOSIS: _____

ACTIVITY	100%* Full duty/no restrictions	75% 45 minutes per hour	50% 30 minutes per hour	25% 15 minutes per hour	0% No activity, no use
Standing					
Walking					
Sitting					
Bending					
Seeing					
Breathing					
Stretching					
Other					

USE OF EXTREMITIES

Upper Circle One: R, L, Both					
Hand, Wrist Circle One: R, L, Both					
Lower Circle One: R, L, Both					

LIFTING: (Indicate pound limitation, horizontal, vertical, overhead, etc.) _____ LB(S).

PUSH/PULL: _____LB(S).

STUDENT'S NAME: _____ LAST 4 DIGITS OF SSN:_____

OPERATION OF MAJOR BODILY FUNCTIONS

Please indicate if any system listed below is affected:

_____ Immune _____ Bladder _____ Circulatory _____ Hemic _____ Bowel

_____ Normal Cell Growth _____ Neurological _____ Endocrine _____ Lymphatic _____ Skin

_____ Digestive _____ Respiratory _____ Reproductive _____ Musculoskeletal _____

Other (specify below):

_____ Special Sense Organs _____ Brain _____ Genitourinary _____ Cardiovascular _____

Please address how each restriction identified on this form affects this person's ability to perform the essential job functions:_____
_____
_____

Frequency he/she is seen for medical condition(s):
_____

Medications being taken for condition(s):
_____
_____

Check all that apply:
_____ These restrictions are temporary and will remain in effect for _____ weeks(s).

_____ These restrictions are permanent.

Please use the space below to address the temporary/permanent nature of the restrictions:
_____
_____
_____
_____
_____

Additional Comments:
_____
_____
_____
_____
_____
_____

Name of Physician (please print): _____

Signature of Physician: _____ Date: _____

Name of Parent/Guardian (please print): _____

Signature of Parent/Guardian: _____ Date: _____