



EXERCISE GUIDELINES FOR ADAPTIVE PHYSICAL EDUCATION

NAME: \_\_\_\_\_ SBVC ID# \_\_\_\_\_

ADDRESS: \_\_\_\_\_ SS# \_\_\_\_\_

PHONE # \_\_\_\_\_

BIRTH DATE: \_\_\_\_\_  MALE  FEMALE

I, the undersigned, request any appropriate person and/or agency or institution to release information consistent with the Federal Family Educational Rights and Privacy Act of 1974, or other laws, regulations, or policies to San Bernardino Valley College. All information will be kept confidential and maintained as a part of my records with Disabled Student Programs & Services. Selected information may be released for mandated State and/or Federal reports.

STUDENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

TO BE COMPLETED BY PHYSICIAN (PLEASE PRINT OR TYPE)

Disability/Condition: \_\_\_\_\_

Prognosis/Status: \_\_\_\_\_

Medications Affecting Exercise: \_\_\_\_\_

Check affects caused:  Drowsiness  Heart Rate  Nausea  Coordination  BP  Mood Change  Other: \_\_\_\_\_

EXERCISE/ACTIVITIES RECOMMENDED

Table with 4 columns: Activity, Yes, No, Comments. Rows include Weight Training, Pool Exercises, Swimming, Stretching, Cardiovascular.

Back/Neck Guidelines (flexion & hypertension): \_\_\_\_\_

Additional Comments: \_\_\_\_\_

Name of Licensed or Certified Physician: \_\_\_\_\_

Address: \_\_\_\_\_

FAX# \_\_\_\_\_ Telephone # \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Send Form as soon as possible to insure a class space for this student:

Mail: San Bernardino Valley College - Disabled Student Programs and Services 701 South Mount Vernon Avenue, San Bernardino, CA 92410

Fax: 909/381-2444

Contact DSPS at 909/384-4443 if you have any questions or concerns.