Los Angeles Valley College

EXERCISE GUIDELINES FOR ADAPTED PHYSICAL EDUCATION

LAVC SID#: 8 8

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____

STREET ADDRESS _____ APT # _____

Date of Birth: ___ / ___ / ___ (MM / DD / YY)

O Male O Female

CITY _____ STATE _____ ZIP CODE _____

Phone ( ) _____

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 Los Angeles Valley College. All information will be kept confidential and maintained as a part of my records with the Services for Students with Disabilities Office. Selected information may be released for mandated State and/or Federal Reports

Student Signature: _____ Date: _____

✱✱✱THIS SECTION TO BE COMPLETED BY THE PHYSICIAN (PLEASE PRINT NEATLY OR TYPE) ✱✱✱
PLEASE COMPLETE BOTH SIDES OF THIS FORM

Disability/Condition: _____

Severity: O Moderate O Severe O Residual; Remission

Disability Related Limitations: _____

THE ABOVE-MENTIONED DISABILITY IS:

___ **Permanent/Chronic (no scheduled updates for diagnosis)**

___ **Temporary (lasting 45 days or longer)** **Ending Date:** _____

Medications Affecting Exercise: _____

Check effects caused: O Drowsiness O Heart Rate O Nausea O Coordination
O BP O Mood Change O Other: _____

EXERCISE ACTIVITIES RECOMMENDED:

	YES	NO	COMMENTS:
Weight Training	O	O	_____
Pool Exercises	O	O	_____
Swimming	O	O	_____
Stretching	O	O	_____
Cardiovascular	O	O	_____
Cycling	O	O	_____

Back/Neck Guidelines (flexion & hypertension): _____

_____

Additional Comments: _____

_____

_____

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1. Type of Exercise	Omit	Mild	Moderate	Unlimited	Remarks:
Lower Extremities					
Pelvic Girdle					
Hip Joint					
Knee Joint					
Ankle Joint					
Foot					
Low Back					
Abdominal Area					
Upper Extremities					
Upper Back					
Shoulder Joint					
Elbow Joint					
Wrist					
Hand					
Neck and Head					
2. Type of Positions:	Limited	Unlimited			
Lying, supine					
Lying, prone					
Sitting					
Standing					
3. Type of Activities:	Omit	Mild	Moderate	Unlimited	Remarks:
Walking					
Running					
Jumping					
Swimming					
Cycling (recumbent bicycle)					

Name of Licensed or Certified Physician: _____ Title: _____

Address: _____ **License #:** _____

_____ **Phone #:** _____

Signature: _____ **Date:** _____

PLEASE SEND/EMAIL/FAX THIS DOCUMENTATION AS SOON AS POSSIBLE TO INSURE A CLASS SPACE FOR THIS STUDENT:

LOS ANGELES VALLEY COLLEGE
SERVICES FOR STUDENTS WITH DISABILITIES
5800 FULTON AVENUE
VALLEY GLEN, CA 91401

PHONE: 818-947-2681
FAX: 818-778-5775
EMAIL: SSD@LAVC.EDU