



Otto-Eldred School District

143 R. L. Sweitzer Drive

Duke Center, PA 16729

(814) 817-1380 opt. 3 Fax 966-3911

Matthew D. Splain, Superintendent

Brenda K. Long, Business Manager

Otto-Eldred Elementary School

5 Bennett Street

Eldred PA 16731

(814) 817-1380 opt. 1 Fax 225-4917

Ryan A. McGinnis, Principal

Lindsay A. Burns, Assistant Principal

Kim S. Alfieri, Guidance Counselor

Otto-Eldred High School

143 R. L. Sweitzer Drive

Duke Center, PA 16729

(814) 817-1380 opt. 2 Fax 966-3911

Harley D. Ramsey, Principal

Lindsay A. Burns, Assistant Principal

Martha Wolf, Guidance Counselor

Dear Parent,

The school laws of Pennsylvania specify that ALL students in attendance in the public schools of the Commonwealth receive instruction in the subject of PHYSICAL EDUCATION (Section 1511). Exception to this course requirement can only be made when the physical education activities will be injurious to the student's health. This exception must be determined by the student's family physician in accordance with Section 1401 of the School Code.

TO BE COMPLETED BY THE FAMILY PHYSICIAN

To Dr. _____,

In regard to the physical education activities of your patient, _____,
We appreciate your cooperation in completing and returning this form.

Nature of Illness or Injury _____

Please indicate those activities in which the student CANNOT participate:

- | | |
|--------------------------------------|-------------------------------|
| _____ Physical Education Tests | _____ Volleyball Skills * |
| _____ Golf Skills* | _____ Volleyball Game |
| _____ Soccer Skills * | _____ Crab Soccer |
| _____ Soccer Game | _____ Weight Lifting |
| _____ Fitness Activities | _____ Badminton |
| _____ Flag Football-Frisbee Football | _____ Stationary Bike |
| _____ Wii, DDR Games | _____ Tennis Skills* |
| _____ Mile Run | _____ Softball |
| _____ Scooter Activities | _____ Aerobics, Yoga, Pilates |
| _____ Basketball Skills * | _____ Walking |
| _____ Basketball Game | _____ Kickball, Mat ball |

**Skills" do NOT require strenuous physical activity.

Please indicate any remedial or corrective work suggested for the student:

_____ ,
This is to certify that I have examined the above named student on _____,
(date)

And recommend that he/she NOT participate in the activities I have indicated for a period of _____ .
(length of time)

Signature of Physician