

ANACORTES SCHOOL DISTRICT

Activity Guidance Modification Request for Elementary Students

Student Name _____ DOB _____

Diagnosis _____ Date _____

Prescribed equipment (Wheelchair, crutches, walking boot, sling) _____

Care needed for school _____

Check the activities/restrictions applicable to this student's condition:

- ☐ No Participation in PE
- ☐ No Participation in outside recess

- ☐ Modified Participation - *Please provide specific guidance:*

Please check APPROVED activities

- ☐ *Activity as tolerated/ Student can self advocate regarding safe activities*
- ☐ *Walking*
- ☐ *Body strength exercises (squats, pushups, planks, wall sits, lunges)*
- ☐ *Balance lesson activities*
- ☐ *Running and running games*
- ☐ *Playground equipment*
- ☐ *Ball activities*

- ☐ No Activity Restrictions

THE ABOVE GUIDANCE WILL REMAIN IN EFFECT UNTIL:

() Student may return to full participation without restrictions on this date: _____

OR

() Until further notice and until fully cleared by medical provider. Date of next appointment: _____

Provider's name _____ Phone _____

Provider's signature: _____ Date _____