

ANACORTES SCHOOL DISTRICT

Activity Guidance Modification Request

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:

These same restrictions will apply to school sports participation and club activities.

☐ **No Physical Activity/ No Participation in PE**

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

Please check APPROVED activities

☐ *Activity as tolerated/ Student can self advocate regarding safe activities*

☐ *Walking/ exercise bike/ stretching*

☐ *Body strength exercises (squats, pushups, planks, wall sits, lunges)*

☐ *Balance lesson activities*

☐ *Running and running games*

☐ *Racket activities (ping pong, badminton)*

☐ *Ball activities (volleyball, basketball, flag football, frisbee etc)*

☐ **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 _____