

Prescribed Medical Accommodations

Elizabethtown Area School District

Middle School Nurse's Office: Tel. (717) 361-7525 ext. 2730, Fax (717) 367-1513

Student Name: _____ **Student Diagnosis:** _____

In order to provide appropriate modifications for this student and better serve his/her needs, we are requesting prescribed medical accommodations.

Please review the below information and check those that apply.

✓ **General and Classroom accommodations:**

- ___ Use of elevator (except in the event of an evacuation, fire, or fire drill)
- ___ Use of crutches, wheelchair, boot, or other assistive device (please list):
- ___ Additional set of books
- ___ Additional time between classes for safe transfer/ambulation/peer help
- ___ Door-to-door peer assistance
- ___ Elevate extremity
- ___ Other: _____

✓ **Physical Education Accommodations:** (also see back of form for additional information)

- ___ No Physical Education/Sports for (define the time limit): _____
- ___ Modified Physical Education/Sports, including
 - ___ Activity as tolerated, allowing student to set limits (self-regulate)
 - ___ No contact sports
 - ___ Upper extremity activities only
 - ___ Lower extremity activities only
 - ___ No running, jumping, or climbing
 - ___ No heavy lifting: _____
- ___ Adaptive Physical Education
- ___ Full activity/no restrictions
- ___ Other: _____

✓ **Concussion Accommodations:**

- ___ Modified School day: (i.e. half days/core classes only/may need to arrive late or leave early)
- ___ Frequent breaks when experiencing symptoms
- ___ Scheduled rest periods during the day
- ___ Tests/learning in a private location
- ___ Reduced workload when possible
- ___ Modified homework assignments/Extended time on homework assignments
- ___ Untimed tests/one test per day
- ___ Preprinted class notes
- ___ Additional time between classes for safe transfer/ambulation/peer help
- ___ Sunglasses or dim room
- ___ Other: _____

Homebound Instruction Request:(Explanation/timeframe) _____

MD/DO signature _____ Date: _____

MD/DO print _____ Phone: _____

(Please turn form over for Physical Education "Can Do List")

Elizabethtown Area School District
Physical Education
"Can Do List"

Dear Physician:

Student's Name: _____ is a student in the EASD. The Physical Education teachers at the Elizabethtown Area Middle School are interested in the well being of this student. In order to better serve this student we would appreciate the completion of this form to give us a better idea of the capabilities of the student at this time.

Thank you.

Health and Physical Education Department
Elizabethtown Area Middle School

****Please circle the activities in which this student may participate safely.****

Weight Room/Cardiovascular Activities	Physical Education Activities
Abdominal Exercises	Volleyball
Aerobics	Basketball
Upper body weight training	Lacrosse
Body weight resistance exercises	Adventure/team-building activities
Core training exercises (stability ball)	Ultimate Frisbee
Elliptical Trainer	Team Handball
Fitness Walking	Kickball-style games
Jogging	Floor Hockey
Lower body weight training	Softball
Rotator Cuff exercises	Speedball
Stationary bike	Soccer
Treadmill	

(Please turn form over for Prescribed Medical Accommodations List)

