WEST ESSEX REGIONAL SCHOOL DISTRICT
ATHLETIC MEDICAL NOTIFICATION FORM

TEMPORARY ACCOMMODATION REQUEST BY
TREATING PHYSICIAN/LICENSED HEALTH CARE PROVIDER

To the Athletic Department,

The following temporary accommodations are recommended for: _____
(Name of Student-Athlete/Cheerleader)
during the time period set forth below:

Start Date: _____ End Date: _____.

Check all that apply:

____ Take rest breaks as needed (may visit the nurse's office, if needed.)

____ Fewer hours at school. Recommend _____ hours per day until _____.
(Date)

____ Shortened classes (i.e., rest breaks during classes). Maximum class length: _____ minutes.

____ Additional time to take tests or complete assignments.

____ Receive help with schoolwork.

____ Reduce time on the computer, reading, and writing.

____ Be granted early dismissal from class to avoid crowded hallways.

____ Check for return of the following symptoms when doing activities that require a lot of attention or concentration: _____ _____
_____.

Physician's/Licensed Health Care Provider's Stamp:

E-Mail _____
Telephone _____
Fax _____

Physician's/Licensed Health Care Provider's Signature: _____ Date: _____

Physician's/Licensed Health Care Provider's Name: (Print Name): _____