

Dover Sherborn Public Schools  
Accommodation Plan for Temporary Disability

Student: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ DOB: \_\_\_\_\_

School: \_\_\_\_\_ Grade: \_\_\_\_\_

Student's Temporary Disability \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Duration of Disability: \_\_\_\_\_

Physician Verification: \_\_\_\_\_

Parent/Guardian Note: \_\_\_\_\_

The following accommodations may be made for this student for the duration of the temporary disability. Accommodations needed for more than 5 school days require physician verification. THE SCHOOL NURSE MAY REQUIRE PHYSICIAN VERIFICATION AT ANY TIME IF DEEMED NECESSARY.

No PE class until \_\_\_\_\_

No outdoor recess until \_\_\_\_\_

\_\_\_ Crutches

\_\_\_ Use of wheelchair

\_\_\_ No running

\_\_\_ Leave early for the next class

\_\_\_ No use of playground equipment

\_\_\_ preferential seating as indicated

\_\_\_ Accompanied on stairs

\_\_\_ Books carried between classes

\_\_\_ Use of elevator

\_\_\_ Rest in health room

Signature of Parents: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Nurse: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Teacher: \_\_\_\_\_ Date: \_\_\_\_\_

Fire Evacuation Plan: \_\_\_\_\_

Transportation Plan: \_\_\_\_\_