ORTHOPEDIC/MEDICAL EQUIPMENT ORDERS FOR SCHOOL

Today's Date:

Student's Name: ___________________________________ DOB:

Diagnosis:

Release to return to school on (date):

ORTHOPEDIC EQUIPMENT AT SCHOOL

Please check and/or comment on the following, as applicable:

□ External support: □ Wheelchair □ Crutches □ Walker □ Other

□ Weight bearing status: □ Non-weight bearing □ Partial weight bearing □ Weight bearing as tolerated □ Full weight bearing

□ Immobilization:

□ Length of time in cast:

□ Follow-up evaluation in:

□ Expected level of discomfort:

□ Pain medication required at school (Physician must complete Medication form)

□ PE Restrictions: (if >10 days, Physician must complete "Physical Education Modifications for Injury or Illness" form)

OTHER EQUIPMENT AT SCHOOL:

Additional Comments/Concerns:

The district nurse is required to reach the prescribing physician to clarify above orders, when necessary, in order to accommodate the student's special need. Changes in student ability may require renewal of these written instructions.

Physician's Signature Date

Physician's Printed Name or Stamp Telephone