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

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