Flagler Schools Assistive Device Authorization

NOTE: SCHOOL BOARD POLICY REQUIRES:
A Physician's or relevant licensed healthcare practitioner's authorization if a student comes to school with an assistive device following an injury or surgical procedure.

AUTHORIZATION (To be completed by Physician or Practitioner)

Student's Name ______________________DOB ____________

The above student is under my medical supervision and has been instructed on the use of this assistive device. I have ordered the use of ________________________due to:

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Approximate Length of Treatment: ____

Physician or Authorized Signature______________________________Date _______________

Address ____

PARENT/GUARDIAN PERMISSION:
I hereby request that my student be allowed to use an assistive device or other support device while in school and away for school activities.

Parent/Guardian Signature __________________________________ **Date** _________________

Parent/Guardian Name _____________________________Address ______________________________

Home Phone ___________________Cell Phone __________________Work Phone ___________________

_______________________________________ ___________________________

School Nurse Signature/Authorized School Personnel **Date**

SCHOOL SHOULD RETAIN THIS FORM IN THE STUDENT'S PROFESSIONAL TREATMENT RECORD