



Board
of Education
Eleanor Juanita
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Julie A. Vitale, Ph.D., Superintendent

ORTHOPEDIC / MEDICAL EQUIPMENT ORDERS FOR SCHOOL

Student's Name: _____ DOB: _____

School Site: _____ Diagnosis: _____

Student able to return to school on (date): _____ Today's 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

_____ _____ Weight bearing as tolerated Partial Weight bearing Full-weight bearing

_____ Immobilization (e.g., splints, cast): _____

_____ Length of time in cast: _____

_____ Follow-up evaluation in: _____

_____ Expected level of discomfort: mild moderate severe

Pain medication required at school (Physician must complete Medication Form.)

Physical Education Restrictions: complete form below

OTHER EQUIPMENT AT SCHOOL: _____

Additional comments/concerns: _____

The school 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's ability may require renewal of these written instructions.

School Nurse/Health Tech

Telephone

Physician's Signature

Telephone



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Physician's Printed Name or Stamp