Richland School District Two
Durable Medical Equipment (DME) Use
Physician Orders

Student Name	DOB	Gr	School
Parent/ Guardian Name and Phone Number:			
Parent/ Guardian Name and Phone Number:			
Physician Name and Phone Number:			
Diagnosis:			

Nursing Goal: Student will use all DME safely while at school and be free from injury.

☐Wheelchair	☐Walker	☐Cane
☐ Wheelchair-bound ☐ Yes ☐ No ☐ Manual Wheelchair ☐ Electric Wheelchair ☐ Ambulatory with DME ☐ Transfers permitted to chair, mat, etc.	☐ Rollator ☐Standard Walker ☐Reverse Walker ☐Temporary- until _____ ☐Permanent use	☐ Standard Cane ☐ Quad Cane ☐Temporary- until _____ ☐Permanent use ☐The student has received instructions on the use of the cane.
Crutches	**Knee Scooter**	**Other**
☐Non-Weight Bearing ☐Toe Touch ☐Partial Weight at _____ % ☐Temporary- until _____ ☐The student has received instructions on the use of the crutches.	☐Non-Weight Bearing ☐Partial Weight _____% ☐Temporary- until _____ ☐The student has received instructions on the use of the knee scooter.	☐ Orthopedic shoe ☐ Cam Walker/ Boot ☐ Orthopedic Brace (Specify Type) _____ Restrictions _____ _____ _____

Specific Instructions for Activity Limitations, Transportation, Field Studies, Other:

_____

Physician's Printed Name _____ **Date** _____
Physician's Signature_____
Phone _____ **Office Nurse's Name/ other contact for questions** _____

Parent's Printed Name_____ **Date** _____
Parent's Signature_____