AUTHORIZATION FOR ORTHOPEDIC INJURY ASSISTIVE DEVICE/HCP Treatment

To be completed by Parent/Guardian:

Student's Name: _____Date of Birth: _____

Medical release

It is necessary for my child _____ to have an Orthopedic Injury Assistive Device during school hours. I hereby give permission for release of medical information pertaining to the orthopedic injury and prescribed assistive device to the School Board of Charlotte County, Florida. I understand it is my responsibility to supply and maintain the prescribed device and ensure that it arrives at the school in working order daily. The school and School Board of Charlotte County, Florida personnel will assume no responsibility for the proper maintenance or delivery of the prescribed assistive device.

Prescribed Assistive Device supplied by Parent/Guardian: _____
Parent/Guardian Name: _____ Phone No._____
Parent/Guardian Address: _____

Signature of Parent/Guardian: _____Date: _____

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To be completed by treating physician/licensed HCP:

Medical Authorization

The above named student is under my medical care for this medical condition and requires an Assistive Device(s) during the school day; the student has been instructed in the use of the prescribed assistive device(s):

Type of Injury _____ Location _____ Injury Date _____

Activity Level (check)

☐ Non-weight bearing ☐ Partial weight bearing ☐ Weight bearing to tolerance ☐ Full weight bearing

Assistive device(s) to be used

☐ Crutches ☐ Wheelchair ☐ Walker ☐ Other _____

Additional Accommodations/Restrictions

☐ Elevator Use ☐ No PE/Recess ☐ Extra time between classes ☐ Other _____

This order is effective until this date _____ Follow-up appointment date: _____

(Please Print)

Licensed Health Care Provider's Name: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Phone No._____ Fax No. _____
Licensed Health Care Provider's Signature_____Date _____