ST. JOHNS CLASSICAL ACADEMY
SCHOOL HEALTH SERVICES

ORTHOPEDIC INJURY ASSISTIVE DEVICE AUTHORIZATION FORM

(To be completed by Healthcare Provider)

Scholar Name _____ Sex _____ DOB _____ Grade _____

School Name _____ Phone _____ Fax _____

Dear Parent/Guardian:
In order for your scholar to use an assistive device during school hours, the school will need the information on this form from you and the health care provider. Please return this completed form to the school health room.

This section is to completed by the parent/guardian

Medical Release

It is necessary for my child _____ to have a special assistive device during school hours. I hereby give permission for release of medical information pertaining only to the orthopedic injury and prescribed assistive device to the St. Johns Classical Academy. This device will be supplied and maintained by me and will arrive at the school in working order daily. The school personnel will assume no responsibility for the use, proper maintenance, delivery of the special assistive device that is necessary, or further injury arising from usage of device. Assistive device supplied by parent: _____

Parent/Guardian Signature:_____ Date:_____

This section is to be completed by the treating physician

Type of Injury_____ Location_____ Date of Injury _____

Activity Level (Please Check) ☐ Non-weight bearing ☐ Partial weight bearing ☐ Weight bearing to tolerance ☐ Full weight bearing

Assistive device (s) to be used_____
Has the scholar been instructed in the use of crutches, or other assistive device(s)☐ Yes ☐ No
Scholar needs extra time changing class? ☐ Yes ☐ No

Comments/Special Instructions/Restriction_____
This order is effective until_____
Date

_____ _____
Physicians Signature Date

Physician Stamp

Signature below indicates that the plan is reviewed and appropriate documentation is complete.

School Nurse Signature _____ Date_____

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