St. Lucie Public Schools
Student Services

Orthopedic Injury Assistive Device Authorization Form

Student Name	Sex	DOB	Grade
School Name	Phone		Fax

Dear Parent/Guardian:
In order for your child 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.

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This section is to be 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 School Board of St. Lucie County, Florida. This device will be supplied and maintained by me and will arrive at the school in working order daily. The school and St. Lucie County Health Department personnel will assume no responsibility for the proper maintenance or delivery of the special assistive device that is necessary.

Assistive device supplied by the parent: _____

Parent/Guardian Signature: _____Date:_____

Parent/Guardian Printed Name: _____Phone #:_____

Parent/Guardian Address: _____

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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 □Crutches □Walker □Wheelchair □Other _____

Has the student been instructed in the use of crutches, or other assistive device(s)? □Yes □No

Comments/Special Instructions/Restrictions_____

This order is effective until_____/_____/_____
(Date)

Physician's Signature_____Date_____

Physician's Printed Name_____Phone_____

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