PSUSD
PALM SPRINGS UNIFIED SCHOOL DISTRICT

ORTHOPEDIC/MEDICAL EQUIPMENT ORDERS FOR SCHOOL

Today's Date: _____

Student's Name:_____DOB: _____ School of Attendance:_____

Diagnosis/Reason for Restriction:_____

Release to return to school on (date): _____Limitation End 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 □ Partial weight bearing □ Weight bearing as tolerated □ Full weight bearing
- Immobilization: _____
  □ Ace Bandage □Suture □Brace □Cast □ Crutches □ Wheelchair
  □Other:_____
- Length of time in cast or immobilized: _____
- Follow-up evaluation in: _____
- Expected level of discomfort: □ High □ Moderate □ Low □ Other:_____
- Pain medication required at school □ Yes □ No (Physician must complete Medication form)
- Physical Education
  □ Regular Physical Education Program: Student can safely participate in all activities without modification _____
  □ Modified Physical Education: Student can participate in regular physical education activities with the following suggested modifications:
  _____
  □ Exemption from Physical Education: Student cannot safely participate in any physical activity from the specified dates:_____ to _____

OTHER EQUIPMENT AT SCHOOL: _____

Additional Comments/Concerns: _____

The school nurse is required to reach the prescribing physician to clarify above orders, when necessary, inorder to accommodate the student's special need. Changes in student ability may require renewal of thesewritten instructions.

_____ _____

Physician's Signature Date

_____ _____

Physician's Printed Name or Stamp Telephone

Parent to Complete this Section / Padre complete esta sección

As the parent/guardian, I hereby give my consent for the above named physician to release the information pertinent to this request. I give permission for my child to return to school under the conditions listed above.

Como padre/tutor, por la presente doy mi consentimiento para que el médico mencionado anteriormente divulgue la información pertinente a esta solicitud. Doy permiso para que mi hijo regrese a la escuela bajo las condiciones enumeradas anteriormente

_____ _____ _____

Parent Signature / Firma De Padre Print Parent Name / Nombre en letra de imprenta Date / Fecha