The Cambridge School

Orthopedic/Medical Equipment Orders for School

This form is to be completed when a student requires orthopedic and/or medical equipment, or activity limitations to accommodate his/her needs at school.

PLEASE RETURN COMPLETED FORM TO THE SCHOOL NURSE

Student's Name ______________________________ Birth Date ______________

Diagnosis ____

Release to return to school on (date) ______________________ Today's Date ______________

PLEASE SELECT AND COMMENT ON ALL THAT APPLIES TO THE STUDENT

The school nurse may need to reach the prescribing physician to clarify these orders, when necessary, in order to properly accommodate the student's special need. Changes in student ability may require renewal of these written instructions.

- **Orthopedic equipment needs at school:**
  ☐ Wheelchair ☐ Crutches ☐ Walker ☐ Other external suport: ______________________
- **Weight-bearing status:**
  ☐ Non-weight-bearing ☐ Partial weight-bearing ☐ Weight-bearing as tolerated ☐ Full weight-bearing
- **Immobilization:** ☐ No ☐ Yes
  Explain ____
- **Length of time in cast:** ____
- **Follow-up evaluation in:** ____
- **Expected level of discomfort:**
  ☐ None ☐ Occassional ☐ Mild ☐ Medium ☐ Severe
  ☐ Other, please explain ____
- **Pain medication required at school:** ☐ No ☐ Yes *(Physician must complete* ***Medications Recommendation*** *form.)*
- **P.E. Restrictions:** *(If >10 days, physician must complete* ***Authorization for Physical Education Post Injury/Illness*** *form.)*
  ____
- **Other equipment needs/additional concerns:**
  ____
  ____
  ____

Physician's Signature ______________________________ Date ______________

Physician's Name *(print)* ______________________________ Phone ______________

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Form may be scanned and emailed to nurse@cambridgeclassical.org