CHULA VISTA ELEMENTARY SCHOOL DISTRICT
84 East J Street, Chula Vista, CA 91910, 619-425-9600

ORTHOPEDIC / MEDICAL EQUIPMENT ORDERS FOR SCHOOL

Student's Name:______________________________ DOB:__________

Today's Date:______________ Diagnosis: ______________________

Student able to return to school on (date):______________

ORTHOPEDIC EQUIPMENT AT SCHOOL (provided by family):
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 (e.g., splints, cast): ______________________________
_______ Length of time in cast: ______________________________
_______ Expected level of discomfort: ☐ mild ☐ moderate ☐ severe
_______ Pain medication required at school (Physician must complete Medication Form)
_______ Physical activity restrictions: complete activity limitations checklist form
_______ Release to full activity on: ______________________________

OTHER EQUIPMENT at SCHOOL:______________________________
____

Additional comments/concerns: ______________________________

The school site nurse will contact the physician if clarification of orders is needed.

______________________________ Health Professional Signature
______________________________ Date

______________________________ Health Professional (Printed Name)
______________________________ CA License Number

______________________________ Telephone
______________________________ fax

HT 12/05/18