Orthopedic Accommodation Form

Student Name:_____Birthdate: _____
School:_____Grade: _____ ID#:_____

My child, _____, had muscle/bone/joint injury and/or surgery. I authorize school staff to follow the orders listed below. I understand new orders are needed when the physician changes activities my child can do or authorizes my child to resume all activities at school.

Physician's Orders

Check or complete all below that apply to the student's restrictions at school.

Type of injury/surgery:_____
Date of injury and/or surgery:_____

PHYSICAL ACTIVITY RESTRCITIONS: START DATE:_____STOP DATE:_____

- ☐ May resume all activities at school without restrictions and/or accommodations.
- ☐ No PE and/or sports activities
- ☐ No recess
- ☐ Low impact activity only, no contact sports. NO use of affected limb.
- ☐ OTHER restrictions (list) _____

WEIGHT BEARING:

- ☐ Full weight bearing on affected limb
- ☐ No weight bearing on affected limb
- ☐ Light toe touch/partial weight bearing only

AMBULATION

- ☐ Wheelchair with leg(s) elevated
- ☐ Wheelchair without leg(s) elevated
- ☐ Crutches at all times
- ☐ Crutches as support only – use based on student's comfort level
- ☐ Walker
- ☐ No stairs
- ☐ Instructed on stairs. May walk up and down stairs without assistance.

PAIN MEDICATION:

Medication	Dosage	Frequency	Times to be given

Medication order effective from: _____ until: _____
Physician's name, address, phone

_____
_____
_____
_____

_____
Physician's signature/date

_____
Parent/guardian signature

_____
Date

Written 11/21/08