OAK PARK ELEMENTARY SCHOOL DISTRICT 97

260 Madison Street. Oak Park. IL 60302
Phone 708.524.3000 - Fax 708.524.3019

Orthopedic Assistive Mobility Device Authorization Form

Parent/Guardian Instructions: In order for your child to use an assistive mobility device during school hours, the school will need the information on this form from you and the healthcare provider. Please return this completed form to your school health office.

Student name (print) _____ Sex _____ DOB_____ Grade _____

School Name _____Phone _____ Fax _____

This section to be complete by the parent/guardian:

Medical release:

It is necessary for my child, _____, to have a specific assistive mobility device during school hours. I hereby give permission for release of medical information pertaining only to the orthopedic injury and prescribed mobility device to OPESD 97. This device will be supplied and maintained by me and will arrive at the school in working order daily. The school and OPESD 97 personnel will assume no responsibility for the proper maintenance, instructional use, or delivery of the mobility device that is necessary.

Assistive device supplied by parent _____

Parent/Guardian Name (Print) _____ Phone _____

Parent/Guardian Signature _____ Date _____

This section to be completed by the treating physician

Type of injury _____ Location _____ Date of Injury _____

Activity Level (check all that apply)

- ☐ Non Weight Bearing
- ☐ Partial weight bearing
- ☐ Upper Extremity Exercises
- ☐ Weight bearing as tolerated
- ☐ Full Weight bearing
- ☐ Other _____

Assistive Mobility Device(s) to be used

- ☐ Crutches
- ☐ Walker
- ☐ Other _____
- ☐ Wheelchair
- ☐ CAM Walker Boot

Has the student been given instructions for proper use of prescribed assistive mobility devices? (circle one) YES / NO

Restrictions (Check all that apply)

- ☐ No PE
- ☐ No Running
- ☐ Indoor Recess only
- ☐ No Stairs
- ☐ No Equipment use or climbing
- ☐ No Large Group Recess
- ☐ No Jumping
- ☐ Indoor Recess if raining/snowing
- ☐ No Interscholastic Sports (if applicable)
- ☐ Other _____

This order is effective until _____ Physician Stamp Below

Physician name (print) _____
Phone _____

Physician Signature _____ Date _____