Orthopedic Injury Health Care Provider Note for School Activity

Student Name:	**Date:**
Provider Name:	**Phone Number:**

Diagnosis:	**Date of Injury:**

Weight Bearing Status/Activity Restrictions

Non-Weight Bearing	☐ **YES**	☐ **NO**
Partial Weight Bearing	☐ **YES**	☐ **NO**
Weight Amount:		
Weight Bearing Time Frame (20 min, only while walking):		
Full Weight Bearing	☐ **YES**	☐ **NO**
Notes:		

Activity Limitation Dates

Start Date:	End Date:
Notes:	

Bathroom Assist

Independent YES ☐ NO ☐ Will need staff assistance while activity is limited.
Notes:

Provider Signature:	**Date:**

Form update 2/2023v2


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Schools
EDUCATING THRIVING STUDENTS