Bartow County School System Physician Documentation for Use of Medical Equipment for Mobility at School

Date _____

Student's Name _____ Date of Birth _____

The above mentioned is under my care or has seen me for treatment and currently requires the use of medical equipment for mobility at school (type of equipment is marked below). He/she has received instructions for the correct usage of the equipment. He/she will be using this equipment for approximately _____ weeks. All necessary equipment must be provided by the parent/guardian.

_____ Crutches

_____ Wheelchair

_____ Walker

_____ Other: _____

_____

Physician's Signature

Physician's Name _____

Address _____

_____

Office Phone Number _____