Bartow County School System Physician Documentation for Use of Crutches and/or Wheelchair at School

Date _____

Student's Name _____ Date of Birth _____

The above mentioned is under my care and currently requires the use of crutches for mobility at school. He/she has received directions for the correct usage of his/her crutches. He/she will be using the crutches for approximately _____ weeks.

_____
Physicians Signature

Physician's Name _____
Address _____
_____
Office Number _____

The above mentioned is under my care and currently requires the use of a wheelchair for mobility due to injury/surgery. He/she has received directions of the correct usage of the wheelchair. The wheelchair has the necessary mechanisms required for safety in accordance with the World Health Organization. He/she will use the wheelchair for approximately _____ weeks.

_____
Physicians Signature

Physician's Name _____
Address _____
_____
Office Number _____