SOUTH PASADENA UNIFIED SCHOOL DISTRICT
Health Services

USE OF CRUTCHES/WHEELCHAIR AT SCHOOL
(REQUIRES THE WRITTEN ORDER OF A MEDICAL PROFESSIONAL)

School: _____

Date: _____

Name of Student: _____

Date of Birth: _____

Grade: _____

To be completed by Medical Provider:
The above named student requires the use of crutches or a wheelchair and has been trained in their proper and safe use.

Diagnosis:
_____
Approximate length of time on crutches: _____
_____
Name (please print) _____
Address_____
Phone_____
Dr. Signature _____
Parent Signature _____

Your professional medical provider is responsible for training your child to properly and safely use medical assistive equipment. The school does not provide assistive equipment and is not responsible for any injury sustained by the improper use of such equipment. Extra passing time will be allowed and assistance will be provided as needed.

_____ _____
Parent signature Date

1/2016