

ORTHOPEDIC AUTHORIZATION FOR POSITIONING WHILE AT SCHOOL

Name of student: _____ Date of birth: _____ Age: _____

This student can bear weight on their feet in the following equipment at school:

- | | | | |
|--|-----------|----------|-------------------|
| <input type="checkbox"/> Stander with AFOs | Yes _____ | No _____ | Time Limit: _____ |
| <input type="checkbox"/> Stander without AFOs | Yes _____ | No _____ | Time Limit: _____ |
| <input type="checkbox"/> Gait Trainer with AFOs | Yes _____ | No _____ | Time Limit: _____ |
| <input type="checkbox"/> Gait Trainer without AFOs | Yes _____ | No _____ | Time Limit: _____ |

This student can be positioned to be seated in the following equipment at school:

- Floor sitter with casters locked or unlocked
- Positioning chair with supports and tray
- Wheelchair with or without tray
- Other: _____

This student can be positioned to lay down on their back or side in the following equipment at school:

- Recliner
- Beanbag/Positioning Pillows
- Floor mat
- Other: _____

Specialized instructions: _____

*If student has surgery/significant medical status change, this form must be updated with the school nurse. If this information is not updated, the school will not be held responsible for any new medical information not shared.

Signature of Physician

NPI #

Date

Address

Telephone

We understand that the school administrator will appoint a qualified designated person(s) who, in accordance with *Education Code* Section 49423.5, will be performing the health care service listed above *and that any nonlicensed qualified designated person(s) who performs the service will do so under the supervision of a qualified school nurse, public health nurse, or qualified licensed physician and surgeon.* We understand that in performing this service, the designated person(s) will be using a procedure that has been approved by our physician.

Signature of Parent/Guardian

Date