Post Operative Health Care Plan

Student:_____ Birth Date:_____ School Year:_____

School:_____ Homeroom Teacher:_____ Grade/Team:_____

Primary Healthcare Provider:_____ Phone Number:_____

Surgeon:_____ Phone Number:_____

Procedures/Operations:_____

Date of Procedure/Operation:_____ Date Child May Return to School:_____

Activity Level During School:
☐ Non-Weight bearing: How long:_____
☐ Weight bearing for transfer/pivot only:
How long: _____
☐ Weight bearing to tolerance: How long:_____
_____
☐ Full weight bearing

Assistive devices to be used:
☐ Wheelchair
☐ Walking device
☐ Crutches
☐ Orthotics:
☐ Other: _____

Child currently receives the following services at school: PT ☐ OT ☐ N/A ☐
May these services be continued during recovery: Yes ☐ No ☐
If yes, restrictions:_____

Pain Management:

Medication Name	Dosage (amount)/Time	When to Use	Given at School
			☐ Yes ☐ No
			☐ Yes ☐ No

SPECIAL CONSIDERATIONS AND PRECAUTIONS (including school activities, sports, and trips:)_____
_____
_____

Physician's Signature:_____ Date:_____

Print Physicians Name:_____ Phone #:_____

Parent/Guardian Signature:_____ Date:_____

School Nurse Signature:_____ Date:_____