



POST-OPERATION INSTRUCTIONS FOR SCHOOL

Student's Name: _____ DOB: _____

School Site: _____

The above named student has recently had surgery:

Diagnosis: _____

Date of the procedure: _____

Type of surgery: _____

Immobilization (e.g., splints, cast) _____

Release to return to school on: _____

Please check and/or comment on the following, as applicable:

_____ Weight bearing status: **NWB PWB WBAT FWB**

[NWB (non wt bearing) PWB (partial wt bearing as tolerated) WBAT (wt bearing as tolerated) FWB (full wt bearing)]

_____ External support: Wheelchair Crutches Walker

_____ Physical education: None Restricted Full Duration: _____

_____ Length of time in cast: _____

_____ Follow-up evaluation in: _____

_____ Expected level of discomfort: mild moderate severe

_____ Post-op pain medication required at school (Please complete attached form.)

Additional comments/concerns: _____

Itinerant Nurse or Site Nurse

Telephone

Physician's Signature

Telephone