Nettle Creek School Corporation

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:	**Assistive devices to be used:**
☐ Non-Weight bearing: How Long ________	☐ Wheelchair
☐ Weight Bearing for transfer/pivot only: How long ________	☐ Walking device
☐ Weight bearing to tolerance: How Long ________	☐ Crutches
☐ Partial Weight bearing: How Long ________	☐ Orthotics: ________________
☐ Full Weight bearing	☐ 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):

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►Physician's Signature◄ ______________________________ ***Date:*** ____________

PRINT Physicians Name: ______________________________ **Phone #:** ____________

PARENT/GUARDIAN SIGNATURE:______________________________**DATE:**____________

SCHOOL NURSE SIGNATURE:______________________________**DATE:**____________