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):

_____
_____
_____

►*Physician's Signature*◄ _____ *Date:* _____

PRINT Physicians Name: _____ **Phone #:** _____

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

SCHOOL NURSE SIGNATURE: _____ **DATE:** _____