



Orthopedic Injury Health Care Provider Note for School Activity

Student Name:	Date:
Provider Name:	Phone Number:

Diagnosis:	Date of Injury:
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Weight Bearing Status/Activity Restrictions

Non-Weight Bearing	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Partial Weight Bearing	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Weight Amount:		
Weight Bearing Time Frame (20 min, only while walking):		
Full Weight Bearing	<input type="checkbox"/> YES	<input type="checkbox"/> NO
Notes:		

Activity Limitation Dates

Start Date:	End Date:
Notes:	

Bathroom Assist

Independent
YES <input type="checkbox"/> NO <input type="checkbox"/> Will need staff assistance while activity is limited.
Notes:

Provider Signature:	Date:
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Est. 1883

B E N D  L A P I N E

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EDUCATING THRIVING STUDENTS