



flaglerschools
Striving to be the Nation's Premier Learning Organization

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NOTE: SCHOOL BOARD POLICY REQUIRES:

A Physician's or relevant licensed healthcare practitioner's authorization if a student comes to school with an assistive device following an injury or surgical procedure.

AUTHORIZATION (To be completed by Physician or Practitioner)

Student's Name _____ DOB _____ School _____

The above student is under my medical supervision and has been instructed on the use of this assistive device. I have ordered the use of _____ due to:

Approximate Length of Treatment: _____

Physician or Authorized Signature _____ Date _____

Address _____

PARENT/GUARDIAN PERMISSION:

I hereby request that my child be allowed to use an assistive device or other support device while in school and away for school activities.

Parent/Guardian Signature _____ Date _____

Parent/Guardian Name _____ Address _____

Home Phone _____ Cell Phone _____ Work Phone _____

School Nurse Signature/Authorized School Personnel

Date

SCHOOL SHOULD RETAIN THIS FORM IN THE STUDENT'S PROFESSIONAL TREATMENT RECORD