SUSSEX COUNTY PUBLIC SCHOOLS

POST OPERATIVE HEALTH CARE PLAN

Please return this post-operative health care plan to your child's school nurse

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 _____ □Weight Bearing for transfer/pivot only: How long _____ □Weight bearing to tolerance: How Long _____ □Partial Weight bearing: How Long _____ □Full Weight bearing	□Wheelchair □Walking device □Crutches □Orthotics: _____ □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 #:_____

I, this child's parent/guardian, authorize disclosure of information to be shared with pertinent school staff so that my child's medical needs may be served while in attendance in the Sussex County School District. This authorization expires as of the last day of the school year.

►Parent/Guardian's Signature◄ _____ Date: _____