WARWICK VALLEY CENTRAL SCHOOL DISTRICT

Health Services
Medical Assistive Device Permission Form

Date:_____

A. Parent Certification:

Please allow my child, _____,
Student Name
_____, to use the following medical assistive device, as per Dr._____,
Date of Birth

Assistive Device:

- ⬜ Crutches
- ⬜ Knee Scooter
- ⬜ Wheel Chair
- ⬜ Other: _____

(See Note Attached).

My child has been instructed in the proper use of the prescribed medical assistive device and I hereby release and hold harmless the District from any and all liability, loss, damage, claims, or actions (including cost and attorney fees) for any injury, permissible by law, arising from the use of the medical assistive device while in the District. Furthermore, I confirm that my child has been instructed that the prescribed device is for their use only and is to be used only as a mobility aid. I understand my child will have help with their books, but will not receive one to one adult supervision.

Parent/Guardian Signature: _____

Parent Phone Number: _____

Student Signature: _____

Date: _____

B. Doctor/Health Care Provider Certification- Complete below or attach doctor's note/orders.

Please allow _____, to use the medical assistive device specified above in school until further notice. He/she has been instructed on its use.

This is to confirm that no physical education classes/recess/ sports (if applicable) are permitted until further notice due to the following injury:
_____.

The follow-up/ reevaluation date is scheduled for: _____

Doctor/Health Care Provider Name: _____

Doctor/Health Care Provider Phone Number: _____ _____
Office Stamp