LOS ANGELES UNIFIED SCHOOL DISTRICT
Division of Special Education

BUL-2087.1 ATTACHMENT A
November 18, 2013

(SCHOOL LETTERHEAD)

Physician Authorization for MOVE Participation

MOVE (Mobility Opportunities Via Education) is a program designed to teach students basic, functional motor skills needed for relative independence within the school, home, and community environments. Activities are designed to assist students in developing the physical skills necessary to sit independently, bear weight on their feet, and take reciprocal steps. The program uses instructional techniques and specialized equipment designed to assist students, to the maximum extent possible, to achieve head control, sitting balance, progressive standing ability, and progressive ambulation ability, skills needed to move from one place to another, self-feed, self-toilet, and participate in leisure-time activities. MOVE affords students, who would otherwise be in a wheelchair or reclining position, the opportunity to be upright and to participate more actively in the instructional program. A physical therapist is available to consult with the teachers to assure safe implementation of the MOVE program.

Student Information (PLEASE PRINT LEGIBLY)
Date: _____
Name of Student: _____ Date of Birth: _____/_____/_____

Attending Physician's Statement (PLEASE PRINT LEGIBLY)
Diagnosis: _____
Description of Student's Medical Condition: _____
_____
_____

Additionally, based on history and physical examination, does the student have any of the conditions listed below that would in any way impact the student's participation in MOVE activities? Provide a brief description:

☐ Dislocated hip _____
☐ Hip flexion contractures _____
☐ Knee contractures _____
☐ Ankle contractures _____
☐ Scoliosis _____
☐ Heart/circulatory problems _____
☐ Other (please describe) _____

Indicate below if there are any known medical contraindications to the above named student participating in the program described above, which could include some or all of the following: being placed in a seated position, being placed in a progressive weight bearing, standing position, and beginning ambulation program?

☐ Yes, there are contraindications. Please specify: _____

☐ No contraindications are noted at this time.

Physician's Signature _____**, M.D.** **Date** _____

Physician's Name (Print) _____**, M.D.** **Phone:** (_____)_____

Psychiatrist: ☐ Yes ☐ No **FAX:** (_____)_____

Address_____ **City**_____ **Zip** _____

For further information regarding MOVE, please call _____ **at**_____

Please return original form to (address of school of attendance): _____