Physician's Prescription for Occupational and/or Physical Therapy Services for Students

Student Name: _____ **Parent/Guardian Name:** _____

Home Address: _____

DOB: _____ **Serving School:** _____

The student has been determined eligible for school based ____ **Physical Therapy** ____ **Occupational Therapy**

Area of Concern: _____

By signing this, the doctor deems prescription medical necessity and agrees with functionally based therapy within the school environment.

TO BE FILLED OUT BY PHYISICAN

Medical Diagnosis and Description of Disability:

History (onset of disability, etiology, pertinent surgery, seizures, medications, etc):

Precautions:

In case of any noticeable physical findings, the occupational/physical therapist will contact you promptly by telephone in regard to proper treatment to be followed.
It is our procedure to request a new prescription for each school year.

CHECK THE APPROPRIATE STATEMENT:

- ☐ 1. I authorize treatment as necessary.
- ☐ 2. I DO NOT authorize treatment.

Physician's Comments:

_____ _____

Physician's Signature Date

Please Print: Physician's Name: _____ **NPI Number:** _____

Phone: _____ **Address:** _____

Please Return Completed Form:

Iroquois Special Education Association
106 E. Front Street
Gilman, IL 60938
Phone: 815-683-2662 Fax: 815-683-9913