

Prescription for Physical and/or Occupational Therapy

Student Name:

Physician:

Date of Birth:

Address:

Educational Diagnosis:

City: State: MI Zip:

District:

Physical Therapist:

Occupational Therapist:

Proposed Treatment (Effective September 1,)

Physical Therapy

Occupational Therapy

- Gross Motor Skills
- Range of Motion/Stretching
- Gait Training
- Mobility and Transfers
- Muscle Strengthening
- Other:

- Fine Motor Skills
- Activities of Daily Living
- Feeding/Eating
- Sensory Motor Integration
- Visual Perceptual Skills
- Other:

Comments :

Comments:

Physical Therapist: _____ Occupational Therapist: _____

Physician Authorization

This prescription is valid for up to one year and may include assistive technology device services as necessary.

Precautions/Comments: _____

Physician Signature: _____ Date: _____