



LEYDEN AREA SPECIAL EDUCATION COOPERATIVE

10401 GRAND AVE., FRANKLIN PARK, IL 60131

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Michael T. McElherne, Ed.D.

Director

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

NOTE: PLEASE USE BLACK INK

Date Received at LASEC

Student's Name (L,F,M) School Year

Parent/Guardian Name

Home Address

Birthdate Operating School

Reason for Prescription Request: TO PROVIDE OCCUPATIONAL/PHYSICAL THERAPY SERVICES FOR THIS SCHOOL YEAR.

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

TO BE FILLED OUT BY PHYSICIAN

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 Address Phone

Treating Therapist(s)

PLEASE RETURN THIS FORM TO THE ABOVE ADDRESS