LIVONIA PUBLIC SCHOOLS

Student Services

PHYSICAL THERAPY/OCCUPATIONAL THERAPY PRESCRIPTION

Student Name_____ Birth date_____

Address_____

As part of this student's educational program, the following goals which require the facilitation of the PT and/or OT:

PT: Generalized stretching/strengthening, endurance training, balance/coordination activities, monitor fit/function of braces as necessary

OT: Fine motor activities, ADLs, sensory strategies

OTHER: Evaluate and treat per educational goals

Because of State Law, we are unable to provide therapy for this student *without a current written prescription signed by a physician.* **This prescription is valid for 1 year from the date of signature.** Please have this **signed and dated** by a physician and returned to school as soon as possible.

To be completed by the Physician:

Diagnosis_____

Precautions_____

Prior Surgical History_____

Further Recommendations_____

_____

Please return via fax or mail to:

Student Services/Central Office
Attn: Physical Therapy Department
15125 Farmington Road
Livonia, Ml 48154
Phone: (734) 744-2615
Fax:(734) 744-2574

_____
Physician signature **Date**

_____
Print name of Physician
NPI #:_____

Address_____

_____

Phone #_____