

Prescription Request for School-Based Physical Therapy

Student's Name: _____ **Date of Birth:** _____

School: _____

The Physical Therapy evaluation conducted by the _____ School District recommends Physical Therapy for

_____ , _____ time (s) _____
student name frequency duration

Goals to be addressed per IEP include:

1. _____
2. _____
3. _____
4. _____

This document serves as a prescription for _____ to receive physical therapy treatment and evaluations as needed and within the limits of his/her IEP.
Student name

Signing below, allows this document to serve as a prescription for physical therapy based on IEP team and Physical therapy evaluation recommendations.

Signature of Physician Date Printed Name