RURAL CHAMPAIGN COUNTY SPECIAL EDUCATION COOPERATIVE
807 N. Mattis Ave, Champaign, IL 61821
(217) 892-8877 FAX (217) 893-8627

OCCUPATIONAL THERAPY PHYSICIAN PRESCRIPTION FORM

CHILD'S NAME: _____ **BIRTHDATE:** _____

SCHOOL ATTENDING: _____ **CLASSROOM:** _____

PARENTS: _____ **PHONE:** _____

ADDRESS: _____

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PARENT PORTION

☐ I give my permission for Occupational Therapy services for my child. I understand that a copy of the Therapist's report will be sent to the Physician.

My Physician's Name: _____

Address: _____

_____

PARENT'S SIGNATURE: _____ **DATE:** _____

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PHYSICIAN PORTION

Reason for OT Referral: _____

_____

Diagnosis: _____

Medications: _____

Surgeries: _____

Complicating Factors: _____

Precautions/Contraindications: _____

_____

Comments/Recommendations: _____

_____

_____

PHYSICIAN'S SIGNATURE: _____ **DATE:** _____