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

PHYSICAL THERAPY PHYSICIAN PRESCRIPTION FORM

PARENT/GUARDIAN PORTION

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

SCHOOL ATTENDING: _____ **CLASSROOM:** _____

PARENT/GUARDIAN: **PHONE:** _____

ADDRESS: _____

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

My Physician's Name: _____

Address: _____

_____

PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

PHYSICIAN PORTION

Reason for PT Referral: _____

_____

Diagnosis: _____

Medications: _____

Surgeries: _____

Precautions/Contraindications: _____

_____

Comments/Recommendations: _____

_____

_____

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