St. Lucie Public Schools
Florida Exceptional Student Education
772-429-3600

Physician's Prescription For Physical Therapy

Student Name:	**Identification #:**
School:	**Date of Birth:**

Diagnosis/Presenting Problem:

The above student has been examined by me on _____/_____/_____and may benefit from physical therapy.*
(Date)

RECOMMENDATIONS

- ☐ **Initial Evaluation/Treatment if Indicated***
- ☐ **Reevaluation/Treatment if Indicated***
- ☐ **Continue therapy plan if indicated**

TREATMENT AREAS

- ☐ **Muscle strengthening**
- ☐ **Range of motion**
- ☐ **Positioning**
- ☐ **Decrease/Increase muscle tone**
- ☐ **Coordination activities**
- ☐ **Wheelchair/Assistive Devices**
- ☐ **Gross Motor**
- ☐ **Gait**
- ☐ **Orthotics**
- ☐ **Other**_____

Physician's Comments:

Precautions/Contradictions:

Physician's Signature:** _____ _____ _____ **Please print Physician's name and address below signature.	**Date:** _____/_____/_____

*Physical Therapy may be provided by the school system when the student's condition/disability may interfere with his/her educational progress.

Please return this form to:
OT/PT Department
The School Board of St. Lucie County

Exceptional Student Education
9461 Brandywine Lane, Port St. Lucie, FL 34986

White: ESE Audit File Yellow: Parent/Adult Student Pink: Therapist XED0050 Rev. 8/04