The School Board of St. Lucie County, Florida
Exceptional Student Education
772-429-4570

Physical Therapy Plan of Treatment

Student Name:		
School: #:		DX:
Student ID#:		DX Code:
Medicaid #:		ESE Program:
DOB:	Physician:	
Grade:	Teacher:	
IEP Date:	Reeval Date:	
Therapist Name:		
Signature: Name/Credentials		Date:

Special Therapy Methods to be Provided

GM: Gross Motor Activities
GTM: Gait Training Mobility
PC: Parent Contact
R/F: Relaxation/Facilitation
WC: Wheelchair Training
TC: Teacher Consultation
MDC: Physician Contact
MCT: Monitor Classroom Therapy
PCG: Training of Primary Care Giver
TSP: Training of School Personnel
Tr/Transit:: Transfers/Transition Skills
ROM/Str: Range of Motion/Strengthening
BAL/COORD: Balance/Coordination Activities
D/C/MON A.D.: Dismissal/Monitor Assistive Device
W/C A/M: Wheelchair Assessment/Modification
POSIT/L: Program/Positioning Treatment Coordination

Medical Alert:

_____________________________________ qualifies for educationally relevant Physical Therapy services. Services may be provided by a PT and/or a PTA and include direct/indirect and/or group therapy. Recommend ____________________ minutes per week _______________times per week for the duration of the current IEP. ESY ______________ minutes per week ____________ times per week.

Description of Student's Present Level of Functioning:

List if Student has Behavior Plan or Accommodations:

Long Term

Short Term Goals:

	Date Mastered