CLARENCEVILLE SCHOOL DISTRICT
Special Education Department

☐ Occupational Therapy
☐ Physical Therapy

Student's Name: _____ Birthdate: _____

Address: _____

Parents: _____ Home Phone: _____

School District: _____ School Attending: _____

Diagnosis REQUIRED: _____

SPECIFIC PRECAUTIONS
Physician's Comments for Activity Limitations:

_____

Atlantoaxial Subluxation/Dislocation Present _____ yes _____ no

Precautions:_____

_____

Seizures: _____

Medications: _____ May participate in gym? _____

Other (specify): _____ May participate in swimming?_____

OCCUPATIONAL THERAPY TREATMENT GOALS (PRESCRIPTION)

_____

_____

PHYSICAL THERAPY TREATMENT GOALS (PRESCRIPTION)

_____

_____

UNDER STATE REGULATIONS AND SCHOOL BASED HEALTH SERVICES REQUIREMENTS, WE ARE UNABLE TO PROVIDE OCCUPATIONAL THERAPY OR PHYSICAL THERAPY FOR YOUR PATIENT WITHOUT A CURRENT WRITTEN PRESCRIPTION. THIS PERSCRIPTION MAY BE VALID FOR ONE YEAR IF SPECIFIC BEGINNING AND END DATES SO STATE.

_____ _____
Signature of Physician Print Name of Physician

_____ _____ _____
Physician's Address Begin Date End Date

_____ _____
City, State, Zip Code Phone Number

Please return to: Clarenceville School District
Special Services Office
20210 Middlebelt
Livonia, MI 48152
Phone: (248)919-0290 **FAX: (248)919-0432**