Wakulla County Schools

MEDICAL PRESCRIPTION FORM

Date:_____

Student Name:_____ Date of Birth: _____ Student #:_____

Address: _____ City: _____

Dear Physician:

The above named student has been referred for, or has been receiving physical therapy as a part of the regular public school program. In order for this student to receive this service, a current medical prescription is necessary. Please complete, sign, and return all copies of this form to the address below:

Wakulla County School Board
ESE Department
69 Arran Rd.
Crawfordville, FL 32327

PHYSICIAN'S USE ONLY

Diagnosis:_____

Medication:_____

Precautions/Other Comments:_____

PHYSICAL THERAPY

At least one of the areas below must be checked for the child to receive physical therapy services:

- ☐ Developmental Motor Evaluation and training
- ☐ Perceptual and Fine Motor Evaluation Training
- ☐ Therapeutic Exercise
- ☐ Feeding Evaluation/Training in Self-Feeding
- ☐ Breathing Exercises/Postural Drainage
- ☐ Splinting
- ☐ Sensory Motor
- ☐ Gait/Mobility Training
- ☐ Functional Living Skills
- ☐ Catheterization
- ☐ Other

_____ _____

Physician's Name (Type or Print) Physician's Signature

_____ _____

Address Date

_____

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