Prescription Request for School-Based Occupational Therapy

Student's Name:_____ **Date of Birth:**_____

School: _____

The Occupational Therapy evaluation conducted by the _____ School District recommends occupational therapy for

_____, _____ time (s) _____
student name frequency duration

Goals to be addressed per IEP include:

1. _____
2. _____
3. _____
4. _____

This document serves as a prescription for _____ to receive occupational therapy treatment and evaluations as needed and within the limits of his/her IEP.
Student name

Signing below, allows this document to serve as a prescription for occupational therapy based on IEP team and occupational therapy evaluation recommendations.

_____ _____ _____

Signature of Physician **Date** **Printed Name**