PHYSICIAN'S PRESCRIPTION FOR PHYSICAL AND OCCUPATIONAL THERPAPY SERVICES FOR STUDENTS IN SPECIAL EDUCATION

Physician prescription for physical and occupational therapy service for the school year _____

Student Name _____ ID# _____ Date _____
Therapist **Louis Kyros**
Therapist's phone 708-372-7285 Fax **708-222-5877**

PHYSICIAN'S REPORT

Medical history of past year and/or changes in medical status:

_____
_____
_____

Current medications (Please include dosage and frequency):

_____
_____

Added precautions:

_____
_____

Additional comments:

_____
_____

The above report and recommendations have been reviewed by me:

Physician's Signature _____
Physician's Name _____
(Please print or type)
Address _____
_____

Phone _____ Date _____

If you would like to discuss this child's case further, please contact the therapist at the above phone.

Please return this completed form as soon as possible to:

Morton West High School
2400 South Home Avenue
Berwyn, IL 60402
Attn: Louis Kyros