

 **School District U-46**

OT/PT Department

Specialized Student Services

355 E. Chicago Street, Elgin, IL 60120-6543

Tel: 847.888.5000 x4272

Fax: 847.888.5320

**U-46.org**

ISO 9001:2008 Certified Quality Management System

Padre: Por favor de proveer la información que se pide en la parte superior de esta forma. Entréguesela al médico de su hijo(a) para obtener la firma e información que se pide en la parte inferior de esta forma.

Tony Sanders, Chief Executive Officer

**POR FAVOR REGRESE LA FORMA COMPLETADA A LA OFICINA DE TERAPIA OT/PT A LA DIRECCIÓN/FAX INDICADO EN LA PARTE SUPERIOR DE ESTA FORMA.**

**PERMISO PARA OBTENER LOS DOCUMENTOS DEL ALUMNO**

**Dr./Professional:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Fecha:** \_\_\_\_\_\_\_\_\_\_ **Ano Escolar:** \_\_\_\_\_\_\_\_\_\_\_

**Dirección:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Alumno:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Ciudad/ Estado:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Fecha de nacimiento**: \_\_\_\_\_\_\_\_\_\_\_ **Grado:** \_\_\_\_\_\_\_\_

**Teléfono:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Escuela:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **OT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Los Terapistas Ocupacionales y físicas del Distrito Escolar U-46 tienen mi permiso para obtener/compartir reportes médicos y consultas, evaluaciones y reportes anuales, y recetas para los servicios de Terapia. Por favor tome en cuenta que este permiso es valido por un ano** **desde el día en que fue firmado**.

# Padre/Tutor: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dirección:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Teléfono:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Firma del Padre/Tutor:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Correo electrónico:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

## PHYSICIAN’S ORDER FORM

**Please complete the items below and return to the address or fax as indicated above. By signing this form, Physician is in agreement educationally based therapy service as identified in the Individual Educational Plan. Please be advised that this form will be valid for one year from the date signed.**

**Medical Diagnosis and/or Description of Disability:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Current Medication:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Precautions or Contraindications:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Additional Comments:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician’s Name (please print):** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Physician’s Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **NPI#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE RETURN THE COMPLETED FORM TO THE OT/PT THERAPY OFFICE AT ADDRESS/FAX STATED ABOVE.**

**THANK YOU**

 **Yes, I would like a copy of the therapy portion of the IEP. No, I do not request records to be sent at this time.**