PT/OT Form 3
Revised 04/26/12

PHYSICAL THERAPY & OCCUPATIONAL THERAPY TREATMENT RELEASE FORM

Dubois-Spencer-Perry Exceptional Children's Co-op

☐ 1520 St. Charles Street, Ste. 2
Jasper, IN 47546
(812) 482-6661 Fax: (812) 482-9381

☐ 319 S. Fifth St., Room 15
Rockport, IN 47635
(812) 649-9991 Fax: (812) 649-9997

Student's name _____ Date of Birth_____

Student's Disability_____

_____
Student's Physician Phone

_____
Address

_____
City State Zip

☐ I give my permission for the above named physician to release/exchange verbal and written information regarding the above named student with the Dubois-Spencer-Perry Exceptional Children's Co-op.

_____ _____
Parent/Guardian Signature Date

PHYSICIAN'S REFERRAL

I authorize _____ to be treated by: Check the appropriate box or boxes:
Student

☐ Physical Therapist

☐ Occupational Therapist

☐ Both Occupational & Physical Therapist

_____ _____
Physician's signature* Date

*** Must be signed by a licensed physician, podiatrist, psychologist, chiropractor, or dentist**.

Precautions/Limitations/Additional comments: _____

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