



SWCCCASE Physician Consent Form for School-Based Occupational and/or Physical Therapy

The following student has been referred for Occupational and/or Physical Therapy:

Student's Name: _____ Birthdate: _____ District of Residence: _____

Parent or Legal Guardian: _____

Address: _____ City: _____

Treatment will focus on: OT: _____

PT: _____

Therapist's Signature: _____ Therapist's Phone Number: _____

By law, we are required to obtain your consent for Occupational Therapy treatment and a medical diagnosis for Physical Therapy treatment. Please complete this request for information. Thank you for your time.

Parent Signature/DCFS Representative (if student is in foster care): _____

Physician's consent:

Diagnosis: _____

Precautions or Special Instructions: _____

Current Medication: _____

Special Equipment the child already has: _____

Consent for Treatment: _____ Date: _____

Physician's Signature

Name of Doctor: _____

Address: _____ City: _____

Phone: _____ Fax: _____

Please return this form with any pertinent medical information to the OT/PT Department at Southwest Cooperative, 6020 W. 151st Street, Oak Forest, IL 60452 or fax to (708) 687-5695.