

**PUBLIC REFERRAL & PARENT PERMISSION FORM  
PHYSICAL THERAPY/OCCUPATIONAL THERAPY**

STUDENT: \_\_\_\_\_ DATE: \_\_\_\_\_

BIRTHDATE: \_\_\_\_\_ GENDER: \_\_\_\_\_ PHONE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

ACCESS ELIGIBLE: YES \_\_\_ NO \_\_\_ ETHNICITY: \_\_\_\_\_ PA SECURE ID NUMBER: \_\_\_\_\_

PARENTS/GUARDIAN: \_\_\_\_\_ (mother) \_\_\_\_\_ (father)

HOME ADDRESS: \_\_\_\_\_  
(Street) (City) (State) (Zip)

PUBLIC SCHOOL DISTRICT OF RESIDENCE: \_\_\_\_\_

PUBLIC SCHOOL BUILDING ATTENDING: \_\_\_\_\_ GRADE: \_\_\_\_\_

HOMEROOM TEACHER: \_\_\_\_\_

DIAGNOSIS/EXCEPTIONALITY: \_\_\_\_\_

REASON FOR REFERRAL: \_\_\_\_\_

THIS EVALUATION IS PART OF A SCHOOL AGE:  INITIAL EVALUATION  RE-RE-EVALUATION  504

DATE PTE/PTR RECEIVED BY DISTRICT: \_\_\_\_\_

TYPE OF EVALUATION/ASSESSMENT: (may include observations, functional tests, interviews, standardized tests)

(Please circle): PT OT PT/OT

Services requested but no evaluation/additional data needed due to student transitioning into program with existing IEP with PT and/or OT services.

\_\_\_\_\_  
Signature of Public School Supervisor

\_\_\_\_\_  
Date

**PARENT/GUARDIAN**

I give permission for my child to be assessed by the appropriate therapist(s) and for services to be added to my child's IEP as recommended.

I authorize Appalachia Intermediate Unit 8 to contact my child's physician to coordinate care/request prescription for services.

STUDENT'S PHYSICIAN: \_\_\_\_\_ PHYSICIAN PHONE: \_\_\_\_\_

PHYSICIAN ADDRESS: \_\_\_\_\_  
(Street) (City) (State) (Zip)

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

**FOR OFFICE USE ONLY**

THE CHILD IS IN NEED OF: \_\_\_ PT \_\_\_ OT IEP UPDATED? \_\_\_ YES \_\_\_ NO

Attach copy of physician prescription –forward to ACCESS Secretary