APPALACHIA INTERMEDIATE UNIT 8
CUSTOMIZING LEARNING SOLUTIONS

4500 Sixth Avenue, Altoona, PA 16602
(814) 940-0223 – Fax: (814) 949-0984

PUBLIC SCHOOL AGE REFERRAL & PARENT PERMISSION FORM
PHYSICAL THERAPY/OCCUPATIONAL THERAPY

STUDENT: _____ **DATE:** _____

BIRTHDATE: _____ **SEX:** _____ **PHONE:** _____ **CELL:** _____

ACCESS ELIGIBLE: YES _____ NO _____ **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-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 Official 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