Four Rivers Special Education District

936 West Michigan

Jacksonville, Illinois 62650

Phone: (217) 245-7174 Fax: (217) 245-5533

**RETURN TO SCHOOL for SCHOOL BASED THERAPY**

Return To: Four Rivers OT/PT Department File No. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Student Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Please provide precautions and/or restrictions that may apply to the above mentioned student that may impact school function/participation:**

May return to **school based physical therapy** on this **date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRECAUTIONS/INSTRUCTIONS:**

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**Physician’s signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Physician’s name (Print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician’s Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Physician’s NPI #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**THIS FORM WILL NOT BE ACCEPTED UNLESS ALL BOLD ENTRIES ARE COMPLETED.**