Grant Parish School Board
Special Education Services
P. O. Box 208 - 512 Main Street
Colfax, Louisiana 71417
Phone: 318-627-5944
Fax: 318-627-3105

DATE: _____

STUDENT NAME: _____

SCHOOL: _____

Dear Parent/Guardian:

As you know, your child is eligible to receive Physical and/or Occupational Therapy service in accordance with their current evaluation. This therapy will emphasize motor development and self-help skills so they relate to the child's educational needs. State Law requires that we have a current doctor's referral for treatment in order for your child to receive therapy. So that you child may participate, both you and the doctor must sign. Please complete and return this form to:

Grant Parish School Board
Special Education Services
P. O. Box 208
Colfax, Louisiana 71417

Thank you,

SHARIL A. MAY, Supervisor
Special Education Services

PHYSICAL AND/OR OCCUPATIONAL THERAPIST SIGNATURE: _____

TO BE COMPLETED BY PHYSICIAN:

I am referring _____ **for evaluation and treatment by the Physical and/or Occupational Therapist through their school program.**

PERTINENT MEDICAL DIAGNOSIS OR INFORMATION: _____

_____

PHYSICIAN SIGNATURE: _____ **DATE:** _____

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TO BE COMPLETED BY PHYSICAL AND/OR OCCUPATIONAL THERAPIST:

The Physical and/or Occupational Therapist requests the doctor's referral to improve the student's functioning in:

___Visual-Perceptual/Motor Skills, Eye/Hand Coordination

___Therapeutic Exercises _____

___Gross Motor Development **___Fine Motor Development**

___Self-Help Skills **___Gait Training**

___Other: (EXPLAIN) _____

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PARENT/GUARDIAN SIGNATURE: _____ **DATE:** _____
(Parent/Guardian MUST Sign)