



**ALPENA-MONTMORENCY-ALCONA
EDUCATIONAL SERVICE DISTRICT**
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PHYSICIAN'S PRESCRIPTION FOR THERAPY SERVICES
_____ **School Year**

STUDENT:	DATE OF BIRTH:
MEDICAL DIAGNOSIS:	
PHYSICAL/OCCUPATIONAL THERAPIST:	

This prescription is valid for one school year of school based therapy services as outlined in the student's Individualized Education Plan. The purpose of school based therapy is to provide services in the student's least restrictive environment so that he/she can maximize his/her potential in the educational setting.

Please incorporate the following into this child's educational therapy program:

- | | |
|---|--|
| <input type="checkbox"/> Fine motor skill training | <input type="checkbox"/> Gross motor skill training |
| <input type="checkbox"/> Mat activities | <input type="checkbox"/> Self-help skills training |
| <input type="checkbox"/> Mobility training | <input type="checkbox"/> Adaptive equipment/assistive devices |
| <input type="checkbox"/> Transfer training | <input type="checkbox"/> Sensory-motor activities |
| <input type="checkbox"/> Developmental motor training | <input type="checkbox"/> Joint protection/energy conservation techniques |
| <input type="checkbox"/> Positioning techniques | <input type="checkbox"/> Other: _____ |

Comments:

Physician's Signature:

Date:
