



**ELIM CHRISTIAN SCHOOL
PHYSICAL THERAPY PRESCRIPTION**

The information on this form will remain in effect from the date of signing through August 31, 20_____.

Student _____ Birth date _____

TO BE COMPLETED BY PARENT/GUARDIAN:

I give my permission for the release of therapy reports, medical and/or diagnostic information regarding my child from the below named physician.

Parent/guardian signature _____ Date _____

Address _____ Phone (____) _____

City _____ State _____ Zip _____

TO BE COMPLETED BY PHYSICIAN:

Physical Therapy Treatment, if necessary

Student's diagnosis _____

Are there any precautions or contra-indications for this student? Yes No

If **yes**, please comment:

Physician's signature _____ Date _____

Physician's name (please print) _____

Address _____ Phone (____) _____

City _____ State _____ Zip _____



Please fax completed and signed form to Elim Christian School at 708-389-0671. Thank you.