



Parental Consent Form for Physician Contact
(Re: Occupational Therapy and/or Physical Therapy Prescriptions)

I, _____, parent of
(Parent's Name)

_____ give Sunshine
(Child's Name)

Developmental School permission to send my child's Individualized Education Plan or OT/PT progress report to Sunshine's school doctor, Dr. Madeline R. Lalia and/or to my child's physician listed below,

Pediatrician's Name: _____

Address: _____

Phone #: _____

Fax #: _____

in order to facilitate the receipt of prescriptions for the recommendation of treatment in Occupational Therapy and/or Physical Therapy.

Parent Signature

Date

Please return this form to Leah Papantonis

Doctor, Nurse Practitioner or Physician Assistant
Order for School Health Related Support Services

Student Name: _____
First Last

Birth Date: ____/____/____ NYC Student ID: _____
Month Day Year OSIS#

I have reviewed the recommendations on the student's IEP with respect to the therapies below and in my opinion, the following services are deemed medically necessary:

For each therapy on the student's IEP, mark one column and include ICD Code (s)

Please blacken a circle only for services on the IEP

	Service IS Medically Necessary	Service, as written, IS NOT Medically Necessary	ID Code(s) associated with each service
Occupational Therapy	<input type="radio"/>	<input type="radio"/>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div>
Physical Therapy	<input type="radio"/>	<input type="radio"/>	<div style="border: 1px solid black; height: 20px; width: 100%;"></div>

Ordering Doctor, PA or NP's Signature (an original signature is required) _____ Date _____

Ordering Doctor, PA or NP's Name _____ Ordering Doctor, PA or NP's License Number _____

Address (Street) _____ Ordering Doctor, PA or NP's NPI Number _____

Address (City, State, ZIP) _____ Ordering Doctor, PA or NP's Medicaid Provider ID Number _____

Telephone Number _____