PHYSICIAN AUTHORIZATION FORM

Please Return to:

Student Name:

Date of Birth:

Primary Educational Disability:

Physician:

Health related services included in this child's IEP/IFSP for one year from through

	Services	How Long	How Often
☐	Developmental & Assistive Therapy (Services provided in order to promote normal development by correcting deficits in the child's affective, cognitive and psychomotor/fine motor skills development. Services include the application of techniques and methods designed to overcome disabilities, improve cognitive skills and modify behavior.)		
☐	Medical Consultation		
☐	Mental Health Counseling		
☐	Nutrition Services		
☐	Occupational Therapy		
☐	Personal Care		
☐	Physical Therapy		
☐	Rehabilitative Nursing Services		
☐	Speech, Hearing & Language Services		
☐	Vision Care Services		

I have reviewed these health-related services and certify that they are medically necessary.

Physician's Signature Date

Physician's Printed Name

Primary Medical Diagnosis (optional):