Please return to:

REGION 10 EDUCATION SERVICE CENTER

OCCUPATIONAL AND/OR PHYSICAL THERAPY RELATED SERVICES ISD/SSA

**PARENT INFORMATION RELEASE FORM**

Dear Parent:

Through the district’s review of existing evaluation and/or transfer data, a therapy evaluation to be administered by a physical therapist (PT) and/or an occupational therapist (OT) and/or ongoing service was recommended for your child. It is requested that a medical referral be completed and signed by a physician or other appropriately certified/licensed medical professional prior to the evaluation to provide the evaluator with additional information and safety precautions. This medical referral is required prior service delivery by a physical therapist (PT) and may be needed by an occupational therapist (OT). Evaluation/service recommendations will address therapy services based on your child’s educational, rather than medical, needs. Periodic update of the parent information release form may be requested.

Student’s Name: Birthdate:

Parent’s Name: Phone:(H) ( ) (W) ( )

Parent to be contacted during the day: Phone: ( )

School District: Campus:

 1. It is often important for the therapist to be able to contact your child’s physician to assist in promoting

 an integrated approach to service delivery within the school setting. Please list all physicians your

 child sees on a regular basis with the phone number.

 NAME PHONE

 ( )

 ( )

 ( )

 2. Does your child receive services from Scottish Rite Hospital? Yes No TSRH#

 3. List other hospitals, clinics, or rehabilitation centers where your child receives services:

 ( )

 ( )

 4. Various substances, foods, liquids may be used during evaluation or therapy. Does your child have any

 known allergies to substances, foods, or liquids? Yes No If YES, please list the allergens, being as specific as possible:

 5. Does your child have any difficulty with choking, swallowing, and/or chewing regular table foods?

 Yes No If YES, please describe:

 6. List concerns that you and your family have for your child in the home/school settings:

 7. List goals/desired educational outcomes that you and your family have for your child in the home/school

 settings:

 8. Do you give your permission for the occupational/physical therapist to contact your child’s physician(s)

 and other past and/or present service providers to obtain and share information? Yes No

This parental release form will remain in effect until withdrawn or updated. Consent may be withdrawn at any time.

 Parent/Guardian’s signature Date

**THIS INFORMATION IS TO BE USED WITH PROFESSIONAL STAFF ONLY IN KEEPING WITH FERPA AND IDEA CONFIDENTIALITY REQUIREMENTS 7/17**

It is the policy of Region 10 Education Service Center not to discriminate on the basis of race, color, national origin, gender or handicap in its vocational programs, services or activities as required by Title VI of the Civil Rights Act of 1964, as amended; Title IX of the Education Amendments of 1972; and Section 503 and 504 of the Rehabilitation Act of 1973, as amended. Region 10 Education Service Center will take steps to ensure that lack of English language skills will not be a barrier to admission and participation in all educational programs and services.