CAMCO
Physical and Occupational Therapy

PARENT PERMISSION TO EVALUATE

Date: _____

Student's Name: _____ DOB: _____

Your child has been referred for _____occupational therapy _____physical therapy assessment in the school environment. We need your consent to proceed with this assessment. Results of the assessment and recommendations will be discussed with you. Please sign below indicating your permission for your child to be evaluated by the appropriate therapist(s).

I give permission for the occupational and/or physical therapist to evaluate my child and to contact my child's physician for the purpose of sharing information related to diagnosis, precautions and recommendations for school-based therapy.

Physician's Name: _____

Physician's Address: _____

_____

Physician's Phone Number: _____

Parent/Guardian Signature Date

Please return this form in the enclosed envelope as soon as possible.
Do not return it to the school.

Thank you for your cooperation and prompt response. If you have questions, please contact Camco at 814-266-8833.

Camco
1454 Scalp Avenue
Johnstown, PA 15904