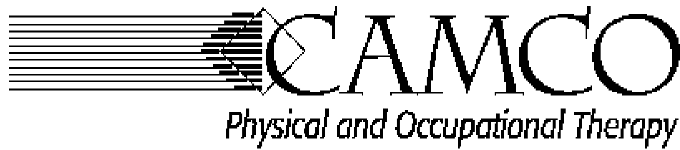

PARENT PERMISSION TO EVALUATE

Date: ___________

Student's Name: ______________________________ DOB: ________________

Your child has been referred for _______occupational therapy _______physical therapy 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 therapist(s) 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.

706 Eisenhower Blvd. Suite 3
Johnstown, PA 15904