

WEXFORD-MISSAUKEE INTERMEDIATE SCHOOL DISTRICT

9907 E. 13TH STREET
CADILLAC, MICHIGAN 49601
231-876-2275 – FAX: 231-876-2272

Date _____

Doctor _____

With your approval, we would like to initiate continue an occupational therapy program for
_____. We have indicated the services the occupational therapy
(name of student)

department at the school district believes would assist the student. If you agree, please sign the prescription
and return to the above address. If you wish to add or change the prescription, please do. If you wish additional
information from us, or if you can provide information to us, it would be helpful. Thank you for your assistance.

OCCUPATIONAL THERAPY PRESCRIPTION

Student _____ Therapist _____

DOB _____ Diagnosis _____

TREATMENT PRESCRIBED

Physicians'
Signature _____ Date _____

Please Print
Signature _____ Termination Date _____

REMARKS: _____

