Vermont Agency of Education

PHYSICIAN AUTHORIZATION FORM

Student Name: Please return to:

Date of Birth:

Primary Educational Disability:

Physician:

Health related services included in this child's IEP 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): ____________________________

July 2013 Date Received by Supervisory Union:_____________