Licking County Educational Service Center Physical Therapy Plan of Care

Student:_____ School Year:_____

Date of Birth:_____ District/ School:

Frequency of Service:_____ IEP DUE DATE:_____ ETR DUE DATE:_____

Areas of Concern Within Classroom/Functional Performance:

☐ Sitting Ability ☐ Transitional Movements ☐ Frequent Tripping/Falling

☐ Ability to Perform Classroom Activities ☐ Performance During Gym Class ☐ Playground Access

Underlying Areas of Concern:

☐ Decreased Strength ☐ Postural Control Skills ☐ Decreased Balance ☐ Coordination Skills

☐ Spatial Awareness ☐ Motor Planning Skills ☐ Decreased Safety

IEP Goals, Frequency, Duration and Location:

Skilled Interventions

☐ Therapeutic Exercise

☐ Core Strengthening Exercise

☐ Gait Training

☐ Balance Activities

☐ Motor Planning Activities

☐ Positioning and/or Adaptations

☐ Range of Motion, Stretching, Flexibility Exercises

☐ Reflex Integration Exercises

☐ Stair Negotiation

☐ Coordination Activities

☐ Safety Instruction

☐ Consult with Parents/Teachers as Needed

☐ Equipment Monitoring/Orthotics/Prosthetics/Skin Integrity

☐ Other: _____

Plan for Discontinuation of Services

The IEP team will consider data for physical therapy services to be discontinued or the Plan of Care to be modified based on one or more of the following events:

1. Goals are Mastered for more than two marking periods.
2. PT is no longer required for the student to benefit from their education.
3. Parent request.

Therapist Signature_____ **Date**:_____

Transfer Therapist Signature_____ **Date:**_____

(If required)