Wakulla County Schools
Exceptional Student Education
Physical Therapy Plan of Care

School year: _____ **IEP Date:** _____ **Plan of Care Date:** _____

Student Name: _____ **Grade:** _____ **Birth Date:** _____

School: _____

Areas of Functional Limitations:

- ☐ Neuromotor
- ☐ Strength
- ☐ Transfers
- ☐ Other:
- ☐ Movement Patterns
- ☐ Sensory/Perception
- ☐ Gait
- ☐ Balance/Equilibrium
- ☐ Fine Motor Skills
- ☐ ROM/Orthopedic

Assessment of Current Status: *See present level on attached Annual Goals & Objectives*

Treatment Plan:

- ☐ Strengthening
- ☐ ROM/Stretching
- ☐ Transfers/Weight Shifting
- ☐ Establish Classroom Plan
- ☐ Coordination
- ☐ Consult with OT/SLP/Vision
- ☐ Developmental Motor Skills
- ☐ Functional Living/Self Care Skills
- ☐ Facilitation of More Normal Movement
- ☐ Home Program/Family Training
- ☐ Staff Training
- ☐ Equipment Needs
- ☐ Gain/Mobility Training
- ☐ Balance Equilibrium
- ☐ Other:

Comments:

Equipment:

- ☐ Glasses
- ☐ AFOs if needed
- ☐ Splints
- ☐ Prone Stander
- ☐ Adaptive Chair
- ☐ Other:

Long Term Goals: *See attached IEP Annual Goals & Objectives*
Short Term Goals: *See attached IEP Annual Goals & Objectives*

Frequency: ___ per_____

Duration: _____minutes

Recommendation:

- ☐ Continue Therapy
- ☐ Discontinue
- ☐ Physical Therapy Consult
- ☐ Not Qualified at this time (see Cert)

Therapist:_____

Date:_____

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