**Precautions:**

**IEP Goals, Frequency, Duration and Location:**

**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.

**Skilled Interventions**

\_\_\_\_ Therapeutic Exercise \_\_\_\_ Range of Motion, Stretching, Flexibility Exercises

\_\_\_\_ Core Strengthening Exercise \_\_\_\_ Reflex Integration Exercises

\_\_\_\_ Gait Training \_\_\_\_ Stair Negotiation

\_\_\_\_ Balance Activities \_\_\_\_ Coordination Activities

\_\_\_\_ Motor Planning Activities \_\_\_\_Safety Instruction

\_\_\_\_ Positioning and/or Adaptations \_\_\_\_ Consult with Parents/Teachers as Needed

\_\_\_\_ Equipment Monitoring/Orthotics/Prosthetics/Skin Integrity

\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**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

Student:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School Year:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_ District/ School:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Frequency of Service:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ IEP DUE DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_ ETR DUE DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Therapist Signature\_\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**\_** **Date**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Transfer Therapist Signature\_**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Date:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **(If required)**