



PHYSICIANS/THERAPISTS/CONSULTANTS

Student: _____ **Date of Birth:** _____ **Grade:** _____

My child is currently a patient or has recently been a patient of the following Physician/Therapist/Consultant. Please know that we at St. Anthony's utilize the team approach to student care. A waiver must be signed before contacting professionals.

NEUROLOGIST: _____ Telephone: _____

PSYCHIATRIST: _____ Telephone: _____

PSYCHOLOGIST: _____ Telephone: _____

(Individual Therapy _____; Family Therapy _____; Social Skills Group _____)

OCCUPATIONAL THERAPIST: _____ Telephone: _____

SPEECH THERAPIST: _____ Telephone: _____

EDUCATIONAL CONSULTANT: _____ Telephone: _____

Signature of Parent/Guardian

Date