Exceptional Student Education

Plan of Care

IEP/FSP Development Date: _____

☐ Indicated as Part of IEP/FSP

Type of Service: ☐ Occupational Therapy ☐ Physical Therapy

Student's Name:_____ School:_____ Medicaid #:_____ DOB:_____

Plan of Care: ☐ Initial ☐ Revised

Description of Student's Current Medical Condition:

Goals/Objectives:

Frequency:_____ Length:_____ Duration:_____ (may be total minutes per week)

Service Discontinued Based on IEP/FSP Recommendation on _____ ☐ No ☐ Yes

(Date)

If yes, state reason _____

Print Therapist Name:_____ Credential:_____

Therapist Signature:_____ Date:_____

Form No.: ESE-2324-037 - Plan of Care / ESE / Forms-General
New Date: 3/21/24

Distribution: ___Cumulative Folder
___Therapist
___Parent
___Medicaid File
___Other

Adapted from Volusia county Public Schools