

Candler County Board of Education
Program for Exceptional Children

IEP ANNUAL REVIEW FOR PHYSICAL THERAPY

Name: _____ SSN: _____

DOB: _____ Age: _____ Grade: _____ School: _____

Parent/Guardian: _____

Address: _____

Present Level of Functioning: _____

Progress or Lack of Progress Noted Since Last Year: _____

Plan or Recommendations for Year: _____

Therapist's Signature

Date