



NAME: \_\_\_\_\_

DOB: \_\_\_\_\_ DATE: \_\_\_\_\_ DISCIPLINE: \_\_\_\_\_

PROGRAM TIME:

HOME EXERCISE PROGRAM:

*Home care services are deemed medically necessary based on child's medical condition. Please see current assessment for detailed plan of care.*

\_\_\_\_\_ has been trained and is competent to perform the above home exercise program.

\_\_\_\_\_  
Signature Date Typed Name Title

\_\_\_\_\_  
Signature Date Typed Name Title