INFORMATION TO PHYSICIAN:
Instruction in the home is one of the most restrictive educational placements available and must be viewed as the placement of last resort to be utilized for the shortest time necessary. Your careful completion of the following information will assist the school to determine whether we can make adaptations for the pupil. Thank you for your assistance.

PHYSICIAN REPORT:

1. What is the diagnosis for this pupil? _____________________________________________
______________________________________________________________________________
______________________________________________________________________________

2. What treatment, if any, is being prescribed?________________________________________
______________________________________________________________________________
______________________________________________________________________________

3. Please specify any procedures being anticipated ____________________________________
______________________________________________________________________________
______________________________________________________________________________

4. Do you anticipate this condition being chronic?_______________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

CERTIFICATION:

Is it medically advisable for this pupil to attend school?

☐ Yes – with the following adaptations/adjustments_______________________________
______________________________________________________________________________
______________________________________________________________________________
☐ No – Specify why __________________________________________________________

___________________________________________________________________________

___________________________________________________________________________

If no, specify length of time student cannot attend school (A minimum of three weeks is required to be considered for the Home/Hospital Program):

___________________________________________________________________________

___________________________________________________________________________

Comments: ____________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Physician’s Signature ___________________________ Date __________________________

Address _____________________________________ Phone _________________________