Lower Merion School District
301 East Montgomery Ave. Ardmore, PA 19003-3399
Phone: 610-645-1903 ♦ fax: 610-645-9531♦www.lmsd.org

Physician's Statement in Support of Homebound Instruction

Date: ______/_____/________

Student's Name: (Please print or type) ____ **Date of Birth:** ___/___/_____

Name of School: (Please print or type) ________________________________ **Grade:** ________

Diagnosis/DSM code: (Please print or type)

____

____

Reason why this illness or disability prohibits school attendance: (Please print or type)

____

____

Prognosis: (Please print or type)____

____

Treatment Plan: (Please print or type)

____

____

____

***Probable duration of the excusal:** (Please print or type) ____

Estimated length of days of confinement for homebound instruction cannot exceed 3 months. Requests for extension beyond 3 months require additional documentation and review by Lower Merion School District and the Pennsylvania Department of Education.

Date student is expected to return to school: ____

The above-mentioned student is under my care and treatment:

Signature of treating physician: ____________________________________ **Date:** _______________

Print name of treating physician: ____

Address: ________________________________ **City:** _________________ **State:** _______ **Zip:** _______

Phone Number: ____________________________ **Fax Number:** _________________________________

***Policy No. 117**