Centerville City Schools
111 Virginia Avenue
Centerville, Ohio 45458
(937) 433-8841 FAX (937) 438-6057

THIS SECTION TO BE COMPETED BY THE STUDENT/PARENT(S):

Name of Student:_____ Date of Birth:_____ID#_____

Address:_____
Street City Zip

Home Telephone Number:_____

Father's Name:_____ Work Phone:_____Cell Phone :_____

Mother's Name:_____ Work Phone:_____Cell Phone:_____

Father's Email address: _____Mother's Email Address:_____

Building of Attendance: _____Grade: _____

Date this form was completed: _____

Physician's Request for Student Home Instruction

Dear Physician,
This student and her/his parent/guardian have requested home instruction for the above named student. This service will be provided only upon your verification that the above named student has a physical or mental condition which prevents this student from having regular school attendance.

This form needs to be completed and submitted to the Centerville City School District before the student can start home instruction. Please note that:

- ✓ *The student will receive a **maximum** of five hours of instruction a week.*
- ✓ *You must provide an estimation about when the student will be able to return to school;*
- ✓ *If the student will be out for longer than nine weeks further documentation will be required about the student's continued need for home instruction.*

If you have any questions, comments or concerns please contact me at 438-6030, extension 2036. Thank you.
Tom Castleman, Attendance and Family Resource Teacher

THIS SECTION TO BE COMPLETED BY THE PHYSICIAN:

Name of Physician: _____

Address: _____

Phone Number:_____**Fax Number:**_____

Date of the Physical Examination: _____

Student's Diagnosis: _____

Does the student's physical and/or mental condition prevent her/him from attending school on a full-time basis?

☐ Yes ☐ No

Does the student's physical and/or mental condition prevent her/him from attending school on a part-time basis?

☐ Yes ☐ No

If you answered "yes" to either of the questions above, please indicate the date upon which you anticipate that the student will be able to return to school on a full-time basis: _____

Physician's Signature:_____**Date:**_____

Date this form was received by Centerville City School District: _____

7/09