Bridgewater-Raritan Regional School District

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INITIAL PHYSICIAN ORDER

FORM B

STUDENTS NAME: _____ Date of Birth: _____Grade:____
(Last) (First)

I. TO BE COMPLETED BY TREATING PHYSICIAN

Treating Physician's Name: _____

Address:_____

Consulting Physician's Name: _____

Address: _____

Date of examination by Treating physician: _____

Diagnosis: _____

Recommendations for special treatment, care, or training:_____

_____

Anticipated duration of absence from school: _____

Is the injury/illness due to any school related activity? Yes No

If yes, please explain: _____

Detailed treatment plan: _____

Oral medication name and dosage: _____

Can the medication be administered at school? Yes No

IV Medication: _____

Surgery: _____

Was the student hospitalized for this condition? Yes No

If hospitalized, please list the hospital name and duration: _____

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FORM B –Continued

Does the patient attend physical therapy? Yes No
If yes, how often and for how long: _____

Does the patient attend/require speech therapy? Yes No
If yes, how often and for how long: _____

Does the patient attend/require occupational therapy? Yes No
If yes, how often and for how long: _____

Does the patient attend/require counseling/therapy? Yes No
If yes, how often and for how long: _____

Does the patient attend/require cognitive therapy? Yes No
If yes, how often and for how long: _____

If it is anticipated the student will be out of school for more than 30 days, please provide a detailed treatment plan and return to school re-entry plan: _____

Will this student need special accommodations to return to school? Yes No
If yes, please list accommodations:_____

Is this student's attendance at school a potential health hazard to him/herself or others at school? Yes No
If yes, please explain: _____

This student may return to school on: _____

Student can return full time with no restrictions or special accommodations on _____ (date)

Student can return to school part time on _____ (date). Please explain part time status:
_____

Student may not return to school. Please explain as to why he/she may not return to school:
_____

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FORM B –Continued

Statement of Physician:	**Please Circle**	
1. This student, in his/her present condition, is physically and mentally capable of profiting from home instruction	Yes	No
2. His/her duration of absence from school will equal or exceed 10 consecutive of 20 cumulative school days.	Yes	No
3. A home instructor can work with this student without subjecting himself/herself to an unreasonable risk of contagion.	Yes	No

Treating Physician's Signature: _____Date: _____

Treating Physician's Stamp: _____Date: _____

II. TO BE COMPLETED BY SCHOOL PHYSICIAN

I have reviewed the report of the treating physician and:

_____ **Concur** with the determination that the Student is eligible for home instruction

_____ **Do not concur** with the determination that the student is eligible for home instruction.

Bridgewater-Raritan School Physician Signature _____ Date: _____

Bridgewater-Raritan School Physician Stamp _____ Date: _____