



# 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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## INITIAL PHYSICIAN ORDER

### 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 or 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: \_\_\_\_\_