



Bridgewater-Raritan Regional School District

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30 CALENDAR DAY FOLLOW-UP PHYSICIAN FORM FORM E

STUDENT'S NAME: _____ Date of Birth _____ Grade: _____
(Last) (First)

I. TO BE COMPLETED BY TREATING PHYSICIAN

Treating Physician's Name: _____

Address: _____

Date of examination by treating physician: _____

Diagnosis: _____

Recommendations for special treatment, care, or training: _____

Anticipated duration of absence from school: _____

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 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**

_____ **do not concur** with the determination that the pupil is eligible for home instruction.

Bridgewater-Raritan School Physician Signature: _____ Date: _____

Bridgewater-Raritan School Physician Stamp: _____ Date: _____