



Wisconsin Department of Public Instruction

**PHYSICIAN'S STATEMENT —
HOMEBOUND INSTRUCTION**

PI-2217 (Rev. 11-11)

INSTRUCTIONS: Physicians—Complete this form and mail it to the student's school district. The district processes this STATEMENT as a referral for suspected exceptional educational needs and retains this STATEMENT in the appropriate file.

GENERAL INFORMATION

Student Name *Last, First, Middle Initial*

Sex

Male Female

Birthdate *Mo./Day/Yr.*

Parent(s)/Guardian(s) Name

Address *Street, City, County, State, ZIP*

PHYSICIAN'S STATEMENT

1. Diagnosis

2. Description of Physical or Emotional Condition

3. Is the student able to attend her/his school program?

Yes No Part-time *Explain*

4. Is the student able to tolerate an instructional program?

Yes No *If no, list medical restrictions which may interfere with the educational program.*

5. Will the student be:

Homebound—Anticipated No. of Days ____ Indefinitely
 Hospitalized—Anticipated No. of Days ____ Indefinitely

6. Where will the student be residing during this time?

Home Nursing Home
 Hospital Other, *Specify*

Physician's Name *Print or Type*

Clinic Name/Office

Address *Street, City, State, ZIP*

Telephone *Area/No.*

Physician's Signature

Date Signed *Mo./Day/Yr.*

