Clairton City School District

School Health Services
501 Waddell Avenue
Clairton, PA 15025
(412) 233-9200 ext. 1124
Fax: (412) 233-4590

Physician's Statement for Home-Bound Instruction

Student Name: ____ Grade: _________

Address: ____

Date of Birth: ___________Parent/Guardian Name: _________________________________

I certify that the above named student has the following disability: _______________________

____

Prognosis: Excellent Good Fair Poor

Mental Health Section (to be completed by the diagnosing psychiatrist):

Is the student mentally/emotionally able to attend a regularly scheduled school day? YES NO

If not, please state the reason: ____

Medical Section:

Is the student medically able to attend a regularly scheduled school day? YES NO

If not, please state the reason: ____

Is the student able to participate in a home-bound program? YES NO

Estimated length of time the student will require home-bound instruction: ________________

The school district provides a maximum of five hours per week for home-bound instruction.

Hours per week student can receive: ______________

Physician's signature: _______________________________________ Date: _____________

Address: ____Phone: ____________

Superintendent's signature: ___________________________________ Date: _____________

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