Fox Chapel Area
SCHOOL DISTRICT

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117-AR-1 Physician's Statement for Homebound Instructions (P-203)

TO BE COMPLETED BY PARENT:

STUDENTS NAME:		DATE OF BIRTH:
PARENT/GUARDIAN NAME:		PHONE NUMBER:
ADDRESS:		
SCHOOL:	GRADE:	DISTRICT: FOX CHAPEL AREA SCHOOL DISTRICT

TO BE ELIGIBLE FOR HOMEBOUND INSTRUCTION STUDENT MUST ANTICIPATE AN ABSENCE FOR A MINIMUM OF 3 WEEKS.

TO BE COMPLETED BY PHYSICIAN:

I find the above named child to have the following disability:

Diagnosis: _____

Description of Disability: _____

Prognosis: _____

Is the child physically unable to attend his regular public school: Yes: No:

Is the child physically able to carry a homebound instructional program? Yes: ☐ No: ☐

Is the child physically able to attend school in a special class for physically handicapped? Yes: ☐ No: ☐

Estimated length of time child will be homebound. Number of weeks: _____

Maximum hours of instruction per week. (5 hours/week maximum allowable) _____

Do you recommend: Sitting ☐ Lying ☐ Writing ☐ Special: _____

Is the ailment communicable? Yes: ☐ No: ☐

PHYSICIAN'S NAME: _____

PHYSICIAN'S ADDRESS: _____

PHYSICIAN'S PHONE: _____

Date Homebound Begins:

_____ _____

PHYSICIAN'S SIGNATURE

NOTE: THE SIGNATURE OF A PSYCHIATRIST IS NECESSARY IF HOMEBOUND INSTRUCTION IS REQUESTED FOR EMOTIONAL DISABILITIES. P-203