Massachusetts Department of Elementary and Secondary Education

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Jeffrey C. Riley
Commissioner

Physician's Affirmation of Need for Temporary Home or Hospital Education for Medically Necessary Reasons

Massachusetts Department of Elementary and Secondary Education regulation, 603 CMR 28.03(3)(c), provides:

> Upon receipt of a physician's written order verifying that any student enrolled in a public school . . . **must remain at home or in a hospital on a day or overnight basis**, or any combination of both, for medical reasons and for a period not less than fourteen school days in any school year, a student is eligible to receive educational services in that setting, temporarily, from the public school district…

All fields must be completed and all required information provided in order for this form to be a valid authorization for service.

RETURN THIS COMPLETED FORM TO YOUR SCHOOL DISTRICT

Student Information:
Student Name: _____DOB: _____
Address: _____ School District Name: _____

Physician Information:
Physician's Name: _____ Telephone #: _____
Type of Authorizer (M.D. or Nurse Practitioner): _____
License #_____
Address: _____

I affirm that it is medically necessary that the above named student must remain on a day or overnight basis:

☐ At home, or ☐ in a hospital or ☐ any combination of both

For a period of:

☐ At least 14 days, or ☐ on a recurring basis that will accumulate to at least 14 days over the

course of the current school year
Medical diagnosis and reason(s) student is confined to the home, hospital or is otherwise unable to attend school for medical reasons:

Date student was admitted to hospital or began confinement at home: _____

If the student also requires a reduction in the regular school workload due to this condition while at home or in a hospital, describe those limitations:

If the student also requires other modification to the educational program while at home or in a hospital due to the medical condition, describe those:

The student is expected to return to school on (Date must be provided) _____.
(*If there is a continued medical need beyond this date, a new signed form from the physician in order to verify the need to continue the provision of educational services in the home and/or hospital).*

Physician's Affidavit of Student's Medical Need for Home/Hospital Services

I am the above-named student's treating physician and am responsible for the student's medical care. I hereby certify that the student must remain at home or in a hospital, or any combination of both, on a day or overnight basis for a period of at least 14 days, or on a recurring basis that will accumulate to 14 days over the course of the school year, for the medical reasons articulated above.

Physician's Signature: _____

Date: _____

For additional information see http://www.doe.mass.edu/prs/sa-nr/default.html or call the Problem Resolution System office (781) 338-3700.

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