

Paterson Public Schools

MEDICAL REQUEST FOR OUT-OF-SCHOOL INSTRUCTION

Section A – to be completed by School Nurse			
STUDENT INFORMATION			
Student's Name	Student's School	Student's D.O.B.	
Student's Home Address	Grade Level	Local ID#	
Name of Student's Parent/Legal Guardian	IEP:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Primary Telephone Number of Parent/Legal Guardian	ELL:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Secondary Telephone Number of Parent/Legal Guardian	504:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Date Form Given to Parent		Date Form Returned By Parent
Section B – to be completed by Student's Physician			
Physician must provide a blank prescription form, which should be marked "VOID" and attached to this request form			
Medical Determination: <i>Health condition or need for treatment that precludes the student's participation in their usual education setting.</i>	Begin Date	End Date	
	<i>Duration of time in which the student's health condition or need for treatment is anticipated to require confinement in an out-of-school setting.</i>		
Is Student currently hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No	By signing below, I certify that this student is under my medical care for the medical condition described above. I further certify that the extent of this medical condition is preventing this student from attending school for the duration indicated above.		
Hospital Name:	Printed Name of Student's Physician		Date
Admission Date:	Signature of Student's Physician		
Section C – to be completed by School Physician			
APPROVAL OR REASON FOR DENIAL			
BEDSIDE INSTRUCTION APPROVED <input type="checkbox"/> Yes <input type="checkbox"/> No			
<i>If Applicable: Duration of time for which School Physician's approval is granted. NOTE: duration cannot exceed (60) sixty days.</i>		Reason (s) for Denial	
Begin Date	End Date		
Printed Name of School Physician	Date	Signature of School Physician	Date