



Is it your opinion that the medical condition prevents the student from physically attending school? If yes, please provide an explanation in support of your opinion.

Is the condition contagious?  Yes  No

If yes, please explain precautions that can be taken by staff who may work with the student:

If the student is placed on homebound/hospital, please identify any medical barriers the student may face with completing assignments at home, if any.

What is the amount of time you estimate the student's medical condition will limit his or her ability to attend school? If more than 15 school days, please explain in greater detail.

The homebound services program is designed to be a temporary educational program to help students who are unable to attend school for medical or psychiatric reasons.

**If the dates of non-attendance will be in excess of six weeks, please provide more information about why you feel the medical condition will lead to a removal of this length. In addition, please complete the *Treatment and School Re-Entry Plan* form. (Attach additional information, if needed.)**

Beginning date of non-attendance: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_      Projected return date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

It is my recommendation that the above student cannot attend school because of illness, accident, or complications from pregnancy—even with the aid of transportation—but may profit from instruction given in the home or hospital.

Printed Name: \_\_\_\_\_ Physician's Signature: \_\_\_\_\_

Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_      Phone: \_\_\_\_\_      Fax: \_\_\_\_\_

Name of Practice/Institution: \_\_\_\_\_

Address: \_\_\_\_\_

Email: \_\_\_\_\_

**SECTION IV: To be completed by BCSS School Personnel:**

Date received request from parent: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Date form given to parent: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Notes: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_