

PHYSICIAN'S REPORT FOR HOME HOSPITAL SERVICES**(To be completed by the attending physician)**

The parents of the student named below have requested home/hospital instruction for their child. To be eligible for this service, a student must be physically unable to attend school for (1) a minimum of three consecutive weeks due to an orthopedic condition or other health impairment as diagnosed by a licensed physician/surgeon or (2) a chronic health condition which will result in the student missing more than 45 days on an irregular basis over the school year.

If in your opinion, this student fulfills the eligibility as stated above, he/she will be assigned a home teacher. Your advice and recommendations will be appreciated.

Student's Name: _____ Grade: _____ Date of Birth: _____

Home Address: _____ City: _____ Zip Code: _____

Parent/Guardian Name: _____ Phone: _____

Diagnosis: _____

Summary of Medical Problem:

Rational for Eligibility: _____Is student physically capable of attending school at this time? Yes ☐ No ☐

Does the home/hospital teacher need to be informed of any special requirements during their home visits?

If "Yes", please explain: _____

Ambulatory ___ Braces ___ Crutches ___ Cast(s) ___ Wheelchair ___ Bedridden ___

How many hours of instruction can the student tolerate per day? _____ hours

Is student contagious? Yes ☐ No ☐ Is the student presently hospitalized? Yes ☐ No ☐

Hospital Name: _____ Expected discharge date: _____

Estimated date student may return to school full time: _____

Physician's Signature _____

Date _____

Office Address _____

City _____

Zip Code _____

Office Phone _____