

**HOMEBOUND OR REDUCED DAY SERVICES: PHYSICIAN'S STATEMENT FORM****TO BE COMPLETED BY THE SCHOOL**

The following student has been referred to our office for homebound or reduced day support due to having a diagnosis that prevents regular school attendance. They are expected to have an absence that exceeds five consecutive days or prevents a full day of attendance.

Student Name_____
Date of Birth_____
Address_____
City_____
State_____
Zip**TO BE COMPLETED BY PHYSICIAN** (Must be an M.D. or D.O.)

If you have any eligibility questions or concerns, please call the District Nurse- Erin Darnell at (517) 817-4729

Diagnosis: Please elaborate, if necessary. For example, pregnancy in and of itself, is not a reason that keeps a student from attending school.

Please check one: ☐ Student is **able** to attend school. ☐ Student is **unable** to attend school AND is confined to the home.
(This is a State of MI requirement for services.)

☐ Student is **unable** to attend a full day of school.
(This is a State of MI requirement for services.)

I understand that Homebound instruction consists of two 45 minute sessions or two 60 minute sessions per week (for students with special accommodation). I understand that reduced day instruction limits the student's access to instruction. Therefore, this service should be short-term, when possible, as it does not replace regular instruction.

Start date of Homebound Services _____ End date or Follow-up Evaluation _____

Start date of Reduced Day _____ Amount of Day to be Reduced _____
End date or Follow-up Evaluation _____

Practice Address_____
Phone Number_____
Physician's Signature_____
Physician's Name (Please Print)