ADMINISTRATIVE REGULATION

WILLIAM PENN SCHOOL DISTRICT

APPROVED:

REVISED:

117-AR-1. PHYSICIAN'S STATEMENT FOR HOMEBOUND INSTRUCTION

To be completed by parent/guardian:

Name of Child: _____ Parent/Guardian: _____

Date of Birth: _____ Address: _____

Grade: _____ Phone Number: _____

School: _____ School District: _____

To be completed by physician:

I find the above-named child to have the following disability:

Diagnosis:

_____

Description of Disability: _____

_____

Prognosis: _____

Is the child physically unable to attend his/her regular school?_____
Is the child physically able to participate in a homebound instruction program? _____
Estimate length of time child will be homebound - number of weeks_____
Maximum hours of instruction per week (5 hours maximum allowable) _____
Do you recommend sitting? _____ Reclining? _____ Writing? _____ Special? _____
Is the illness communicable? _____

_____

Physician's Name/Title (Please print or type)

_____
Address

_____

_____
Date Phone

NOTE: The signature of a psychiatrist is necessary if homebound instruction is requested for emotional and psychological disabilities.

© 2015 PSBA