PENN MANOR SCHOOL DISTRICT

ADMINISTRATIVE REGULATION

APPROVED: March 18, 2011

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 ailment communicable? _____

_____ M.D.
Physician's Name (Please print or type)

_____
Address

_____ _____
Date Phone

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