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WASHINGTON TOWNSHIP PUBLIC SCHOOLS

HOME INSTRUCTION STUDENT'S PHYSICIAN VERIFICATION

Student Name:		Date:	DOB:
School:	Grade:	Counselor:	
General Education Student _____ _____504 _____ I&RS	Special Education Student _____		

Physician Information: The section below must be completed by the licensed physician providing care to the student for the condition for which home instruction is requested.

Date(s) of Examination:	Diagnosis:

Is the student confined to the home and unable to participate in the normal activities expected during school attendance? Yes_____ No_____
Please provide medical facts in support:

Could this student attend school if accommodations are provided? Yes_____ No_____
Please explain:

Student Symptoms:

Explain treatment, dates of treatment and/or ongoing therapy that is being provided (In cases of emotional disorders, please attach treatment plan).

If condition is chronic, please describe diagnosis, treatment, symptoms, expected duration of chronic condition and efforts to have student attend school on a regular and consistent basis.

Prognosis:

Expected Date of Return to School:

Original Physician Signature	***AFFIX Physician Stamp here or provide an attached letterhead identifying the name/address of Medical Practice:***
Indicate Area of Licensed Specialty: MD ____ DO ____ Psychiatrist ____ Neurologist ____ Other _____	