



HOMEBOUND INSTRUCTION MEDICAL FORM

In order to receive homebound services, a student must be medically unable to attend school for a minimum of six weeks or have a condition that may result in intermittent and anticipated absences throughout the school year. We are requesting documentation that home confinement is recommended for this student due to medical needs. Your prompt reply will be appreciated as we are unable to begin services until we have your diagnosis. **PLEASE NOTE: Person County Schools will request additional information or re-authorization, including a treatment plan every 30 days following the execution of this document.** Please provide specific information regarding the following.

TO BE COMPLETED BY A LICENSED HEALTHCARE PROVIDER

Name of Student: _____

Name of Licensed Healthcare Provider: _____

Diagnosis _____

Is this student physically or emotionally unable to attend school? Yes No

If answered yes, please explain _____

Homebound Start Date: _____ Estimated End Date: _____

Upon returning to school, will the student need physical assistance?(Please be specific) _____

Additional comments or restrictions: _____

Physicians Signature: _____ Date: _____

(Office Stamp REQUIRED)

Office address: _____

Office phone: _____