THE SCHOOL DISTRICT OF PHILADELPHIA
SCHOOL HEALTH SERVICES

PHYSICIAN'S REFERRAL FOR HOMEBOUND INSTRUCTION

NAME OF STUDENT	DATE OF BIRTH	STUDENT I.D.	GRADE	RM/SEC/BK

HOME ADDRESS	ZIP CODE	NAME OF PARENT/GUARDIAN	HOME PHONE

NAME OF SCHOOL	SCHOOL TELEPHONE	SCHOOL NURSE

■ TO BE COMPLETED BY PHYSICIAN:

- Date of Examination:_____ Date of Next Appointment:_____
- Diagnosis:_____
- Date of onset of illness:_____ Date of onset injury:_____
- Prognosis:_____
- What physical/clinical findings that make it NOT possible for this student to attend school?

_____

_____

_____

- What medication(s) is this student taking?_____

_____

- Will the student require medication in school? ___ Yes ___ No
- When do you believe this student will be able to return to school?_____
- What, if any accommodation, do you believe will be necessary to facilitate an early return to school?

_____

_____

PHYSICIAN'S NAME (PRINT)	PHYSICIAN'S SIGNATURE	DATE

PHYSICIAN'S ADDRESS	PHYSICIAN'S PHONE NO.

■ PARENT/GUARDIAN AUTHORIZATION:

I authorize the School Nurse to communicate with my child's health care provider and my child's health care provider to reply as needed regarding this Referral for Homebound Instruction

Parent/Guardian's Signature:_____ Date Signed:_____