

PHYSICIAN'S RECOMMENDATION FOR HOMEBOUND SERVICES

STUDENT INFORMATION (PLEASE PRINT)

Student's Legal Last Name

First Name

Date of Birth

Address Number and Street Name – Apt. #

City

Zip Code

Home Phone Number

Alternate Phone Number

School

Grade

Is the above named child unable to attend school because of a medical condition? Yes No

Can the pupil attend school on a part-time basis? Yes If yes, for how long: _____ No

***Pupils able to attend school part-time are expected to do so and do not qualify for homebound/hospitalized service.*

Medical Condition / Diagnosis: _____

Is the student's medical condition contagious? Yes No

Does the medical condition require the child to be confined to the home or hospitalized? Yes No

Can the child physically participate in instructional services at home or while hospitalized? Yes No

***Instructional services are 45 minutes two (2) days a week and Special Education instructional services are 60 minutes two (2) days a week.*

Child restriction/s: _____

What is the probable length of time the student will require homebound services Weeks: _____ Months: _____

Date when services may begin: _____

Physician's Printed Name: _____

Physician Signature: _____ Date: _____

Address: _____ City: _____ Zip Code: _____

Telephone Number: _____ Fax Number: _____

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Office use only

Reviewed and Approved by: _____ Date: _____

Service Provider: _____ Service Start Date: _____

Dearborn Public Schools

Howe School

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