

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: _____