FOX CHAPEL AREA SCHOOL DISTRICT

"Excellence is not an act, but a habit." – Aristotle

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Phone: 412-967-9600
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117-AR-1 Physician's Statement for Homebound Instructions (P-203)

TO BE COMPLETED BY PARENT:

STUDENTS NAME:		DATE OF BIRTH:
PARENT/GUARDIAN NAME:		PHONE NUMBER:
ADDRESS:		
SCHOOL:	GRADE:	DISTRICT: FOX CHAPEL AREA SCHOOL DISTRICT

TO BE ELIGIBLE FOR HOMEBOUND INSTRUCTION STUDENT MUST ANTICIPATE AN ABSENCE FOR A MINIMUM OF 3 WEEKS.

TO BE COMPLETED BY PHYSICIAN:

I find the above named child to have the following disability:

Diagnosis: _____

Description of Disability: _____

Prognosis: _____

Is the child physically unable to attend his regular public school: Yes: ☐ No: ☐

Is the child physically able to carry a homebound instructional program? Yes: ☐ No: ☐

Is the child physically able to attend school in a special class for physically handicapped? Yes: ☐ No: ☐

Estimated length of time child will be homebound. Number of weeks:_____

Maximum hours of instruction per week. (5 hours/week maximum allowable) _____

Do you recommend: Sitting ☐ Lying ☐ Writing ☐ Special: _____

Is the ailment communicable? Yes: ☐ No: ☐

PLEASE PRINT:

PHYSICIAN'S NAME:
ADDRESS:
PHONE:

DATE HOMEBOUND BEGINS: _____

PHYSICIAN'S SIGNATURE: _____

NOTE: THE SIGNATURE OF A PSYCHIATRIST IS NECESSARY IF HOMEBOUND INSTRUCTION IS REQUESTED FOR EMOTIONAL DISABILITIES.

PHYSICIAN INPUT FORM

STUDENT'S NAME:_____

PHYSICIAN'S NAME: _____

ADDRESS: _____

_____

PHONE :_____

MEDICAL DIAGNOSIS THAT MAY LIMIT SCHOOL ATTENDANCE OR PARTICIPATION IN INSTRUCTION:

_____

_____

IS THE STUDENT ABLE TO PARTICIPATE IN INSTRUCTION IN THE SCHOOL ENVIRONMENT?

- ❑ YES
- ❑ YES, WITH LIMITATIONS. PLEASE EXPLAIN: _____
- ❑ NOT ABLE TO ATTEND SCHOOL. IF CHECKED PLEASE COMPLETE PDE FORM 203 (ENCLOSED)

IS THE STUDENT ABLE TO PARTICIPATE IN INSTRUCTION OUTSIDE OF THE SCHOOL ENVIRONMENT? (UP TO 5 HOURS A WEEK)?

- ❑ YES
- ❑ YES, WITH LIMITATIONS. PLEASE EXPLAIN: _____
- ❑ NO

ACCOMMODATIONS THAT MAY BE NEEDED:

- ❑ SHORTENED SCHOOL DAY
- ❑ TEST ACCOMMODATIONS, SUCH AS: _____
- ❑ ASSIGNMENTS MODIFIED, SUCH AS: _____
- ❑ OTHER. PLEASE SPECIFY: _____

DATE: PHYSICIAN'S SIGNATURE:

_____ _____

NOTE:
PLEASE USE THE BACK OF THIS FORM IF ADDITIONAL SPACE IS REQUIRED
THIS INFORMATION MUST BE UPDATED AFTER 90 DAYS.