Homebound or Hospitalized
Physician's Report for Re-entry of Student to School

Student:_____ Student #:_____

Birth Date:_____ School:_____ Reexamination Date: _____

This student is currently served by the Homebound/Hospital Program. Can the student be scheduled to return to school full-time? ☐ Yes ☐ No

If no, can this student be scheduled to attend *part of a day* during a recuperative period of readjustment toward a full school day? ☐ Yes ☐ No

If yes, the student's readjustment period of time will be until:

Comments:

Physician's Name/Title *(please print)*_____

Physician's Signature *(MD or OD required)*_____

Address:_____

Telephone Number:_____ Date:_____