PITTSGROVE TOWNSHIP SCHOOL DISTRICT

Physician's Request for Home Instruction Form

(To be completed by the treating physician or APN and approved by the Pittsgrove Township School District's Board approved Physician) We will ONLY accept the Original Physician's signature. NO stamps, faxes, e-mails or copies.

Parents please complete section below:

Student's Name: ______________________________________ Date of Birth: _________________

School: ____________________ Grade_____ Phone and email: ____

Parent/Guardian: _________________________________ Address: ____

I certify that the information contained in this document is true and complete. I authorize the district physician to contact my healthcare provider for additional information, if needed.

Parent/Guardian Signature: ____________________________________ Date: ___________

Treating Physician or APN only please complete the following:

______________________________ is under my care for ____

(Please print student's name) (Diagnosis)

Symptoms: ____
Objective findings on physical exam: ____
Diagnostic studies: ____
Consultations/Hospitalizations: ____
Treatment plan: ____
Prognosis: _____________________________________ 7. EDC (if pregnant) ___________________________

This student may be unable to attend school for a period of ______ weeks. **(Please do not omit this estimate).**

The following are recommendations and/or restrictions while on HBI and potential transition plan to return:

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Print Physician's Name: ______________________________________ Date: __________

Phone Number ______________________________

Address: ____

Physician/APN's Signature: ___________________________________ Date: __________

A physician's stamp will not be accepted. This must be signed by the treating physician/APN ONLY.

For District Physician's Use Only:

__________I am approving this home instruction as written by treating physician

__________I am approving this home instruction under the following conditions/requirements:

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__________I am not approving this home instruction because:

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District Physician's Signature: _____________________________________Date: ______________