Summit Academy

Homebound (Hospitalized) Instructional Program

Health Professional's Statement of Needs

This statement is to be completed by the Physician, Psychologist, or Licensed Social Worker/Counselor providing the verification and treatment of the individual listed below, whose condition requires his/her absence from school for a period of 10 consecutive school days or longer.

Student ____

Diagnostic Statement ____

Based upon the above diagnosis, why is the student unable to attend school? ____________
____
____
____

How long will the student require homebound Instruction? ____________________

Is there a risk of contagion? ______Yes ______No

If yes, indicate level of contagion and measures or precautions to be followed by the Home and Hospital Teacher ____
____

Name and Address of the Health Care Professional

____
Name (Print) **Title** **Phone**

____
Address **City** **Zip Code**

____
Signature of the Physician or Health Care Professional **Date**

This form is to be returned to the School Counselor

***Office Use*:**
Date Received: ________________________ By: ____________________________
Teacher Assigned to the Student: ____
Hours/Type of Service: ____

LEA Signature:____Date_______________