WALLINGFORD SWARTHMORE

SCHOOL DISTRICT
200 SOUTH PROVIDENCE ROAD, WALLINGFORD, PA 19086-6334
Student Services Office
(610) 892-3470 x 1509 **FAX (610) 892-3498**

PHYSICIAN'S REFERRAL FOR HOMEBOUND INSTRUCTION

DEMOGRAPHICS	
NAME OF STUDENT:	DATE OF BIRTH:
HOME ADDRESS:	
SCHOOL:	GRADE:
SCHOOL NURSE:	PHONE:

TO BE COMPLETED BY PHYSICIAN:

Physician Name: _____ Specialty: _____

Date of Examination: _____ Date of Next Appointment: _____

Diagnosis: _____

Date of onset of illness/injury: _____

Prognosis: _____

What physical/clinical findings 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 a successful return to school:

_____

_____

_____

PHYSICIAN SIGNATURE: _____

PARENT/GUARDIAN AUTHORIZATION:

By signing this form, I authorize the School Nurse, and/or the Director of Student Services or his/her designee, to communicate with my child's health care provider, and for my child's health care provider to reply as needed regarding this Referral for Homebound Instruction.

PARENT/GUARDIANSIGNATURE: _____

DATE SIGNED: _____