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**To be filled out by the physician:**

Date: \_\_\_\_\_

RE: Request for Home Study for: \_\_\_\_\_ D.O.B. \_\_\_\_\_

School: \_\_\_\_\_ Parent: \_\_\_\_\_ Telephone: \_\_\_\_\_

Dear Physician:

In response to the home study request for the above student, we ask that you review the attached policy which was adopted by the Board of Trustees on December 17, 1991 and revised November 17, 2004. In order to proceed, we will need a written description from you of the disabling condition. Please note that **“temporary disability”** means a disability after which the pupil can reasonably be expected to return to regular day classes without special intervention. Other educational placements will be utilized if the disability is long term. Please complete and sign the lower portion of this letter. Thank you.

1. Please describe the disabling condition: \_\_\_\_\_  
\_\_\_\_\_

2. Can the pupil be reasonably expected to return to regular day classes or an alternative education program or their existing special education program, if any? \_\_\_\_ Yes \_\_\_\_ No

If **no**, what intervention would be needed? \_\_\_\_\_  
\_\_\_\_\_

3. Home Instruction to Begin Date: \_\_\_\_\_ End Date (Approx.): \_\_\_\_\_

4. Will the student expose the home teacher to any contagious disease that can be transmitted by casual contact? \_\_\_\_ Yes \_\_\_\_ No

Physician’s Name (Please print): \_\_\_\_\_

Physician’s Address: \_\_\_\_\_

Telephone number: \_\_\_\_\_ Fax: \_\_\_\_\_

Physician’s Signature: \_\_\_\_\_ Date: \_\_\_\_\_