Dublin City School District

Home Instruction Physician Referral

The student named below has been referred for home instruction tutoring. State and Federal Law requires a medical evaluation as a part of this process. Please complete this form and return to:

School Counselor Name: ____
School Name: ____
School Address: ____
School phone: ____________________ School fax: ____________________

The Home Instruction Tutoring process will begin when this information is received. If Home Instruction persists beyond nine weeks, the need for home instruction will be reviewed and additional information may be requested for continuation.

All Sections Must be Completed

Thank you for your assistance.

To be completed by the school:

Date: ____________________________

Student name: ____________________________________ DOB: ______________ Gender: ____

Home address: ____

City: ____ State: __________ Zip: ____________

Parent(s) name(s): ________________________________ ________________________________
Father Mother

Phone: _____________________________________ _____________________________________
Father – home work Mother – home work

School: ____ Grade: _______________________

Date student last attended school: ____

Number of absences this school year: Full - _____ Partial - _____ Tardies - _____

To be completed by the physician:

Student's diagnosis: ____

Medications prescribed: ____

Potential side effects: ____

Will student's physical condition preclude the student from attending school: _____________________

Specify reason: ____

____

____

Student will be absent from school: From (date) ________________ To (date) ________________

(OVER)

What is a realistic expectation for school attendance based on diagnosis and student condition? ____

On average, student may miss approximately _____ days per week.

After how may days of absences would you want to be contact by the school? _____

Date of most recent examination: ____________________________

Significant findings from examination: ____

____

____

____

Social, emotional, or behavioral implications of diagnosis: ___________________________________

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____

Medical recommendations for academic and health care plan: _________________________________

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____

Next scheduled appointment: ____

Physician's name: ____
(please print)

Address: ____
(please print)

City: _______________________________________ State: __________ Zip: _____________

Phone: ______________________________________ Fax: ______________________________

Physician's signature: __________________________________ Date: ________________________