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Hollie Wagner
 LCISD - Spec Ed Dept
 Homebound Coordinator

Once this form has been completed please fax to 810-277-3038 Attention Hollie Wagner

MEDICAL REPORT FORM HOMEBOUND/HOSPITALIZED

Name _____ DOB _____ Sex _____
 Address _____ Phone _____
 School _____ Gr. _____ Parent/Guardian _____

Please fill out COMPLETELY for eligibility consideration

- In your opinion, is the student able to travel to a school building daily to participate in a regular school program?
 _____ Yes _____ No
- Can the student attend school part time? _____ Yes _____ No
- Is the student now hospitalized? _____ Yes _____ No
 If yes, name of hospital _____
 Estimated length of stay _____ May student receive instruction in the hospital? _____
- If/when the student is convalescing at home, do you recommend educational instruction in the home?
 _____ Yes _____ No
- Please estimate the total number of weeks the student will be unable to attend school (include time in hospital and at home): Less than 2 weeks _____ If 2 weeks or more please estimate _____
- Please describe the medical condition(s) that requires the student to be homebound/hospitalized for more than 5 consecutive days?

- Are there any contagious diseases in the home that would make it unwise for a teacher to give instruction in the home? _____ Yes _____ No If yes specify: _____
- Does this student have any additional disability or illness, besides the one being presently treated, of which we should be aware? _____ Yes _____ No
- Other pertinent information which may help us plan for the student's educational program: _____

- I have last examined the patient (date): _____

Physician's Signature (Must be MD, DO, or PA Only)

Physician's Name (typed or printed)

 Address

 Phone

 Date

LCISD USE ONLY

Is this student currently receiving Special Ed Services? _____ Yes _____ No