Livingston EDUCATIONAL SERVICE Agency

MEDICAL VERIFICATION FOR HOMEBOUND / HOSPITALIZATION

Pursuant to Section 388.1709 (1) of the State School Aide Act, public school districts shall provide appropriate instructional services, as determined by the district, to an enrolled pupil who is certified by an attending physician as having a medical condition that requires the pupil to be hospitalized or confined to the his/her home during regular school hours and that is expected to require hospitalization/confinement for a period longer than five days.

Student Name:_____ Birthdate: _____

Medical Condition: _____

Medication(s): _____

Anticipated Length of Hospitalization or confinement to the home:

Start date:_____ Anticipated end date: _____

As a certified physician, I acknowledge that this student manifests a medical condition that requires hospitalization or confinement to the home.

Physician Signature: _____ Date: _____

Physician/Practice Information. Please type or print.

Physician's Name: _____

Practice Name: _____

Address: _____ Telephone Number: _____

When completed, please mail/fax to: _____

District Contact Name, Title

_____

District Name

_____

District Address

_____ _____

District Phone *District Fax*