School District Name:
School District Address:

Physician's Statement for Temporary Home or Hospital Education

603 CMR 28.03(3)(c)

Student Information:

Student Name: _____ DOB: _____

Address: _____

Physician's Information:

Physician's Name: _____ Telephone #: _____

Type of Physician: _____

Address: _____

The student will require educational services ☐ at home and/or ☐ at a hospital:

- ☐ for more than 14 days.
- ☐ for recurrent periods of less than 14 days, that will accumulate to more than 14 days in the school year.

The school district should consider the following medical information when planning instructional services:

The student's health during this period(s) ☐ will affect / ☐ will not affect the provision of full educational services. If services will be affected, please explain why and how services will be impacted.

The student is expected to return to school on _____.
(MM/DD/YY)

_____ _____

Physician's Signature Date