Lansing School District

ATTN: _____

DATE: _____

FROM: _____

HOMEBOUND OR REDUCED DAY SERVICES: PHYSICIAN'S STATEMENT FORM

TO BE COMPLETED BY THE SCHOOL

The following student has been referred to our office for homebound or reduced day support due to having a diagnosis that prevents regular school attendance. They are expected to have an absence that exceeds five consecutive days or prevents a full day of attendance.

_____ _____

Student Name Date of Birth

_____ _____ _____ _____

Address City State Zip

TO BE COMPLETED BY PHYSICIAN (Must be an M.D., D.O., or Certified Physician's Assistant)

If you have any eligibility questions or concerns, please call the Office of Special Education at (517)755-4000.

Diagnosis: Please elaborate, if necessary. For example, pregnancy in and of itself, is not a reason that keeps a student from attending school.

_____

_____

Please check one: ☐ Student is **able** to attend school. ☐ Student is **unable** to attend school AND is confined to the home. *(This is a State of MI requirement for services.)*

☐ Student is **unable** to attend a full day of school. *(This is a State of MI requirement for services.)*

I understand that Homebound instruction consists of two 45 minute sessions or two 60 minute sessions per week (for students with special accommodation). I understand that reduced day instruction limits the student's access to instruction. Therefore, this service should be short-term, when possible, as it does not replace regular instruction.

Start date of Homebound Services_____ End date or Follow-up Evaluation _____

Start date of Reduced Day_____ Amount of Day to be Reduced_____
End date or Follow-up Evaluation _____

_____ _____

Practice Address Phone Number

_____ _____

Physician's Signature Physician's Name (Please Print)

Please return completed form within three days of receipt by faxing to (517)755-1029.