

NOTE: This form is used by the Home and Hospital Teaching Office to obtain physician's recommendation and parent's permission to initiate instruction for students with medical problems. Completed form is maintained in the Home and Hospital Teaching Office.

TO BE COMPLETED BY PARENT

Student _____ ID # _____ Sex: M F Date of birth ____/____/____
Last First MI

Address _____
Street City State ZIP Code

Home phone _____ - _____ - _____ Work phone _____ - _____ - _____ Cell phone _____ - _____ - _____

School _____ Grade _____ Last day of school attendance ____/____/____
Present School or Last School Attended

Does the student have a 504 Plan IEP?

Parent/Guardian _____

Remarks _____

I authorize the MCPS school medical advisor to consult, when necessary, with the physician attending my son/daughter to confirm the diagnosis and/or clarify the medical notations. I am aware that MCPS has the right to withhold service until the need for home and hospital teaching has been confirmed by the school medical advisor.

_____/_____/_____
Signature, Parent/Guardian Date

TO BE COMPLETED BY PHYSICIAN

This is to certify that the above named student was examined by me on ____/____/____.
Date

Is home and hospital teaching recommended? Yes No

I will I will not be responsible for the continuing of treatment or supervision during the time he/she is out of school.

Diagnosis _____ Is this a contagious disease? Yes No

If yes, list of precautions to be taken by staff to minimize risk of transmission of disease. _____

If home and hospital teaching is recommended, reason for recommendation. _____

If pregnant, list expected date of delivery ____/____/____

Estimate of time home and hospital teaching will be required. _____

_____/_____/_____
Signature, Physician Date

Address _____ Telephone _____ - _____ - _____

TO BE COMPLETED BY SCHOOL MEDICAL ADVISOR (when necessary)

Recommendation of School Medical Advisor _____

School Medical Advisor name _____ Date ____/____/____