Shiawassee
Regional Education Service District

Parent/Physician Release Form
Homebound Services

Parent Release

Student Name		Date of Birth	
District		Phone #	

My child has a medical condition that confines him/her to the home during regular school hours for a period of more than five school days.

(Physician's name) _____ has my consent to release medical information regarding my son's / daughter's medical condition for the development of educational programming during this absence.

_____ _____ _____
Signature of Parent, Guardian or Student (if of legal age) Date

Medical Information To Be Completed By Physician

Physician's Name _____
(Please type/print)

The SHIAWASSEE RESD must receive physician's statement of impairment before homebound program can be implemented. Homebound services are provided when a student has a medical condition that requires him/her to be confined to home during regular school hours for a period of more than five school days.

Student's Impairment/Illness_____

Is it communicable, infectious or contagious? Yes No

Approximate date student could return to school: _____

Is there a limit of instruction time for health reasons? Yes No If yes, how much time? _____

Student instructional position if applicable: Supine Upright Sitting

Is any medication being taken that affects the student's school work? _____

What medical/physical restrictions should the homebound teacher be aware of during the course of instruction?

_____ _____ _____
Signature of Physician Phone Date

Please return to: Assistant Superintendent for Special Education
Shiawassee RESD
1025 N. Shiawassee Street
Corunna, MI 48817
Phone: 989.743.3471 Fax: 989.743.9601