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Hollie Wagner  
LCISD - Spec Ed Dept  
Homebound Coordinator

**Once this form has been completed please fax to 810-664-1011 Attention Hollie Wagner**

## MEDICAL REPORT FORM HOMEBOUND/HOSPITALIZED

Name \_\_\_\_\_ DOB \_\_\_\_\_ Sex \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_  
School \_\_\_\_\_ Gr. \_\_\_\_\_ Parent/Guardian \_\_\_\_\_

**\*Please fill out COMPLETELY for eligibility consideration\***

1. In your opinion, is the student able to travel to a school building daily to participate in a regular school program?  
\_\_\_\_\_ Yes \_\_\_\_\_ No
2. Can the student attend school part time? \_\_\_\_\_ Yes \_\_\_\_\_ No
3. Is the student now hospitalized? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If yes, name of hospital \_\_\_\_\_  
Estimated length of stay \_\_\_\_\_ May student receive instruction in the hospital? \_\_\_\_\_
4. If/when the student is convalescing at home, do you recommend educational instruction in the home?  
\_\_\_\_\_ Yes \_\_\_\_\_ No
5. Please estimate the total number of weeks the student will be unable to attend school (include time in hospital and at home): Less than 2 weeks \_\_\_\_\_ If 2 weeks or more please estimate \_\_\_\_\_
6. Please describe the medical condition(s) that requires the student to be homebound or hospitalized for more than 5 consecutive days? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
7. Are there any contagious diseases in the home that would make it unwise for a teacher to give instruction in the home? \_\_\_\_\_ Yes \_\_\_\_\_ No If yes specify: \_\_\_\_\_
8. Does this student have any additional disability or illness, besides the one being presently treated, of which we should be aware? \_\_\_\_\_ Yes \_\_\_\_\_ No
9. Other pertinent information which may help us plan for the student's educational program: \_\_\_\_\_  
\_\_\_\_\_
10. I have last examined the patient (date) \_\_\_\_\_

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Physician's Name (typed or printed)

\_\_\_\_\_  
Address

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Date

**To qualify for services this Medical Form must be signed by an M.D. or D.O.**

### LCISD USE ONLY

Is this student currently receiving Special Ed Services? \_\_\_\_\_ Yes \_\_\_\_\_ No