Park City School District

Home Health (Physician Form)

(Must be completed by physician, medical professional, licensed mental provider.)

Student's Name: ______________________________ DOB ___________________

School _____________________________ Grade __________________

Parent/Guardian's Name _________________________Cell Phone ______________________

To the Doctor: This student & parent/guardian have requested home health educational services.

Medical information is required to provide this service.

Diagnosis ____

Treatment/Medication ____

Date treatment began for this diagnosis: ______ Anticipated ending treatment date: _________

Is this child receiving psychological counseling? ___________ How often? _________________

Please Print: Physician's name: _______________________________________

Address ____ Phone _____________________

Signature of Physician ____ Date _____________
(Please do not use a stamp. This form must be signed by a licensed physician.)

Education Recommendation

Please check one of the following, which will give this child the best educational advantage. Please check only one.

______1. This child is physically able to attend classes in a regular school with accommodations

as follows: ____

______2. This child is physically unable to attend classes, even with accommodations. Specify

the number of weeks needed for home health instruction ___________________________