High Point Regional High School
Physician's Request for Home Instruction Form

Part A: Parents please complete section below:

Student's Name _____ Date of birth_____

Address_____ Phone Number_____

_____

Parent_____ Alternate number_____

Parent/Guardian Signature _____ Date_____

In signing this form, I give permission for the Chief School Physician to contact the Treating Physician to release information regarding the information below.

Part B: Treating Physician ONLY please complete the following:

_____ is under my care for_____

(Please **print** student's name) (Diagnosis)

Treatment plan: _____

(Please include details to transition student back into the school community)

In my opinion, this student may be unable to attend school for a period of _____ days/weeks.

Estimated date of return REQUIRED. _____

If student is out beyond this estimated date a reevaluation will be required.

Print Physician's Name: _____ Phone Number_____

Address: _____ City/State/Zip_____

Physician's Signature _____ Date: _____

Physician's stamps will not be accepted. This must be *signed* by the treating physician ONLY.

Part C: For HPRHS School Physician Use Only:

_____ I am approving this home instruction for _____ days/weeks.

_____ I am not approving this home instruction because _____

Please fax form to: Guidance Dept at (973)875-1083. Call (973)875-3101 x1252 if you have any questions or need assistance with this form.