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

(To be completed by the treating physician)

Parents please complete section below:

Student's Name ________________________________ Date of birth__________________

Address_______________________________________ Phone Number________________

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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.

Treating Physician ONLY please complete the following:

To: HPRHS Chief School Physician:

________________________________ is under my care for_____________________________

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

1. Diagnosis: ____

2. 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.

For HPRHS School Physician Use Only:

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

_____ I am not approving this home instruction because ____

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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.