Naperville 203
Community Unit School District

Christine Igoe
Assistant Superintendent for
Student Services

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HOME/HOSPITAL PHYSICIAN CERTIFICATION

TO BE COMPLETED BY A PHYSICIAN LICENSED TO PRACTICE MEDICINE IN ALL ITS BRANCHES (M.D. or D.O.):

Student Name: _____ Student DOB: _____

DIAGNOSIS (Please fill in the following)

Disease/Injury/Surgery (Primary Diagnosis): _____

Other (Please describe): _____

If disease, is this disease communicable? ☐ Yes ☐ No If yes, please provide instruction to school staff in the space below labeled "***Special Recommendation to Teachers***"

I certify that this student is unable to attend public school and is medically eligible and physically eligible to be enrolled in the following program:

Check one only ☐ Home Instruction ☐ Hospital Instruction

The physician must estimate that the student will need the home/hospital instruction for a minimum of 10 school days this school year. The time may be longer than 10 days. Estimate length of time student will need home/hospital instruction this school year (in weeks):

_____

SPECIAL RECOMMENDATION TO TEACHER (concerning diet, rest, exercise, positioning): _____

_____

_____

For School District Use Only Date home/hospital Instruction began: _____	_____ Print Name of Physician _____ Physician Contact Telephone Number _____ ORIGINAL Signature of Physician Date