SAGINAW TOWNSHIP COMMUNITY SCHOOLS
Community Services Department - Homebound Services
3465 N. Center Road, Saginaw, Michigan 48603
Phone: (989) 797-1847 Fax: (989) 797-1801

MEDICAL STATEMENT
Homebound/Hospitalized Student

To be completed by the student's Physician

Student's Name: _____ Birth Date: _____/_____/_____

Address: _____City/Zip: _____

Phone: _____ Sex: ❑ M ❑ F Age: _____

Parent/Guardian:
_____

I certify that this child has the following condition: (please describe physical or mental disability that is the reason why the student cannot attend school) _____

_____

_____

Is this condition contagious? ❑ Yes ❑ No

The above condition does not restrict this child from being able to receive academic instruction at home or in the hospital, subject to the following restrictions:

Homebound Services Restriction of student (if any) _____

_____

_____

Estimated period of incapacity when student will be unable to attend school; be as specific as possible
_____

_____

Name of Physician (MD): _____

Title _____

Physician Signature _____ Date: ___/___/_____