

GENERAL McLANE SCHOOL DISTRICT

**PHYSICIAN'S CERTIFICATE OF INCAPACITATION
FOR HOMEBOUND INSTRUCTION**

Student's Name _____

1. Nature of illness which renders the student unable to participate in school programs and/or specific activities (incapacitated):

2. Specific period of time during which the student will be unable to attend school.

Incapacitated from: _____
Month Day Year

to: _____
Month Day Year

3. Date or dates of treatment and/or examination(s):

4. I recommend that the General McLane School District provide homebound instruction to the above named student.

Signature of Physician

Typed Name

Address

Degree or Major Field of Practice Date