



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):

- 3. 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

****"HOMEBOUND INSTRUCTION IS PROVIDED ONLY FOR SERIOUS ILLNESS OR DISABILITY."**