

OFFICE OF HOME AND HOSPITAL TEACHING—PHYSICIAN'S VERIFICATION

Part I: To Be Completed By School Personnel

Name of Student: _____ Home Telephone: _____

School: _____ Student #: _____

Date DSS-22 Given to Parent: _____ Date DSS-22 Returned to Counselor: _____ School Person Receiving Form _____

Part II: To Be Completed By Doctor

Dear Doctor:

Before initiating Home and Hospital Teaching services, we are required to obtain written verification of the physical condition from a licensed physician. Written verification of an emotional condition must be provided by a licensed psychologist or psychiatrist, or a certified school psychologist. **Continuation of the service beyond 60 calendar days requires written reverification of the service need. Therefore, a new *Physician's Verification* form must be submitted to the school prior to the expiration of the 60 calendar days if the need continues beyond the initial term.**

- Specify the physical/emotional condition that prevents the student from attending his/her school of enrollment. If request is due to pregnancy, indicate the estimated date of delivery:

- Reasons the condition prevents the student from attending school: _____
- Is this condition contagious? No Yes (Describe) _____
- Describe the treatment plan (Attach psychological/psychiatric evaluation if emotional condition.): _____
- What medication is student receiving? Side effects? _____
- Recommendations for school attendance: unable to attend school (Reasons explained in #2 above)
 able to attend school for partial day
 able to attend school intermittently as health permits
- Identify date: To begin service: _____ Duration: _____
- Recommendations regarding school participation: (i.e. activities to avoid, activities to encourage) _____

Physician's Name (Print): _____

Check appropriate box: Physician Psychiatrist Psychologist License Number: _____

Address: _____ Phone: _____

(Physician's Signature): _____ Date: _____

PGCPS Office Use Only

Reviewed by PGCPS Health Services _____ Reviewed by PGCPS School Psychologist _____
Date _____ Date _____