PALISADES SCHOOL DISTRICT

39 Thomas Free Drive
Kintnersville, PA 18930

# PSYCHIATRIST'S CERTIFICATION FOR HOMEBOUND INSTRUCTION

Date Psychiatrist Initiated_____________________________

Name of Student_____________________________________________________________________________

Parent(s)/Guardian(s)________________________________________________________________________

Address_____________________________________________________________________________________

Phone No.______________________________________ Email Address_______________________________

School__________________________________________Grade______________________________________

1. Description of Disability and Summary of Evaluation (Use attachments as appropriate to document tests administered, results, etc.)_______________________________________________

   ____________________________________________________________________________________

2. Describe how this disability restricts regular school attendance_____________________________

   ____________________________________________________________________________________

3. Anticipated date Homebound can begin (Start Date)_____________________________________

4. Anticipated length of need (End Date)______________________________________________

5. What is the maximum number of hours of instruction the child can tolerate per day?__________

6. List specific instructions for the homebound teacher (if necessary)___________________________

   ____________________________________________________________________________________

Name of Psychiatrist_____________________________________________

Address_________________________________________________________

Phone No._______________________________________________________

_________________________________________ _________________

Certifying Psychiatrist's Signature Date

9/26/2016