

TUTORING SERVICE FOR GRADES K – 12
RETURN COMPLETED FORM TO: Cheryl O'Brien
LOWELL PUBLIC SCHOOL
SPECIAL EDUCATION DEPARTMENT
155 MERRIMACK ST. 5TH FLOOR
LOWELL, MA 01852

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Physician's Statement for Temporary Home* or Hospital Education

603 CMR 28.03(3)(c)

Student Information:

Student Name: _____ DOB: _____ School: _____ Grade: _____

Address: _____

Physician's Information:

Physician's Name _____ Telephone #: _____

Type of Physician: _____

Address: _____

The student will require educational services at home and/or at a hospital:

for more than 14 days.

for recurrent periods of less than 14 days, that will accumulate to more than 14 days in the school year.

The school district should consider the following medical information when planning instructional services:

The student's health during this period(s) will affect / will not affect the provision of full educational services. If services will be affected, please explain why and how services will be impacted.

The student is expected to return to school on _____.
(MM/DD/YY)

Physician's Signature

Date