Vernon Parish School Board
Special Education Department
201 Belview Road
Leesville, LA 71446
Phone (337) 239-1689
Fax (337) 392-0368

HOSPITAL/HOMEBOUND REFERRAL

FOR TEMPORARY PLACEMENT DUE TO A PHYSICAL ILLNESS OR INJURY

Pupil's Name_____ Age_____ Date of Birth_____ Sex____

Pupil's School_____

Parent's Name_____ Phone Number_____

Physical Address_____

TO BE COMPLETED BY A PROPERLY CERTIFIED PHYSICIAN ONLY

Medical Certification-Please note that all information below must be completed by a properly certified physician. If all items are not completed, the referral will be returned to the properly certified physician.

1. **Illness, Injury, or Hospital Recovery**
   The undersigned physician certifies that the above named student is unable to attend school for the following reason(s): (Give specific medical diagnosis with brief description.)
   _____
   _____
   _____
2. **Communicable Status**
   The undersigned physician certifies that the above named student is free from communicable or infectious disease and is able to benefit from hospital or homebound instruction with the following limitations or modifications:_____
   _____
   _____
3. **Duration**
   The expected duration of the condition which prevents school attendance is:
   _____3 weeks _____4 weeks _____5 weeks _____6 weeks

Physician's Name: (type or print)_____ Date:_____
Address:_____
Telephone Number:_____
Physician's Signature_____