



PHYSICIAN'S PLAN OF TREATMENT – TRANSITION PLAN

Patient (Student Name): _____ (Student DOB): _____

A. Current disabling condition (describe): _____

B. Describe why the disabling condition is still preventing the student from attending school:

C. Please indicate specific steps planned to return the student to classroom instruction:

Presently, this student may attend school (check as appropriate):

___ 1/4 day ___ 1/2 day ___ 3/4 day ___ Total day

Recommended accommodations:

D. Briefly describe how treatment will be administered and how the student's progress will be monitored. _____

Failure to secure necessary assessments/tests within the initial approved homebound period is not a valid reason for an extension of services.

Name of licensed physician/psychologist/psychiatrist completing form: _____
(Print)

Signature of Licensed Physician/ Psychologist/Psychiatrist/Nurse Practitioner _____

Date Signed : _____

Smart, Safe Schools