



ANCHORAGE SCHOOL DISTRICT  
Health Services/Special Education Department

**Documentation of Student's Medical  
or Mental Health Condition When Special Education  
Student May Require Home Bound Services**

Date: \_\_\_\_\_

Dear Physician or Mental Health Professional:

The special education team at \_\_\_\_\_  
School is planning to meet and review the Individual Education Program for the  
following student:

\_\_\_\_\_ (birthdate: \_\_\_\_\_).

It has come to the attention of the team that you are currently treating this student and  
may have some information that would assist the team in determining appropriate  
program goals, services and placement that will provide a free appropriate public  
education to the student.

Please provide answers to the following questions to assist the team in their educational  
planning. You will find an authorized "Consent for Release of Information" attached to  
this request.

Please contact \_\_\_\_\_ at \_\_\_\_\_ School,  
(phone: \_\_\_\_\_) should you have any questions regarding this request.

Thank you.

**PHYSICIAN OR MENTAL HEALTH PRACTITIONER'S STATEMENT**

Statement of diagnosis: \_\_\_\_\_

Does your long-term treatment plan indicate that the student's medical or mental health condition may interfere with his/her regular attendance at school?

No \_\_\_\_\_ Yes \_\_\_\_\_

If yes, to what degree would you imagine that the student's attendance would be affected over the next six-month period?

---

---

---

---

Is the student medically able to attend school for a partial day?

No \_\_\_\_\_ Yes \_\_\_\_\_

If yes, please describe any special assistance the student might require to attend school for a partial day period (*please include any services that might require school nursing services*).

---

---

---

---

Some students require home instruction for period of time. In such cases and to facilitate the timely review of this student's special education placement, please answer the following questions:

Would your long-term treatment plan indicate that the student could return to school attendance?

No \_\_\_\_\_ Yes \_\_\_\_\_

If yes, please provide information about when you might anticipate such a return (even if partial day) so the team can anticipate such a change in the student's educational needs.

---

---

---

Physician or health practitioner name (please print) \_\_\_\_\_

Signature \_\_\_\_\_

Phone \_\_\_\_\_

Fax \_\_\_\_\_

Date \_\_\_\_\_