Wisconsin Department of Public Instruction
PHYSICIAN'S STATEMENT — HOMEBOUND INSTRUCTION
PI-2217 (Rev. 09-21)

INSTRUCTIONS: Physicians—Complete this form and mail it to the student's school district.

GENERAL INFORMATION

Student Name *Last, First, Middle Initial*	Sex ☐ Male ☐ Female	Birthdate *Mo./Day/Yr.*

Parent(s)/Guardian(s) Name

Address *Street, City, County, State, ZIP*

PHYSICIAN'S STATEMENT

1. Diagnosis

2. Description of Physical or Emotional Condition

3. Is the student able to attend her/his school program?

☐ Yes ☐ No ☐ Part-time *Explain*

4. Is the student able to tolerate an instructional program?

☐ Yes ☐ No *If no, list medical restrictions which may interfere with the educational program.*

5. Will the student be:

☐ Homebound—Anticipated No. of Days ___ ☐ Indefinitely

☐ Hospitalized—Anticipated No. of Days ___ ☐ Indefinitely

6. Where will the student be residing during this time?

☐ Home ☐ Nursing Home

☐ Hospital ☐ Other, *Specify*

Physician's Name *Print or Type*	Clinic Name/Office

Address *Street, City, State, ZIP*	Telephone *Area/No.*

Physician's Signature ➢	Date Signed *Mo./Day/Yr.*