



WOODBIDGE SCHOOL DISTRICT
 Student Services Office
 16359 Sussex Highway
 Bridgeville, DE 19933
 Telephone: (302) 337-7990
 Fax: (302) 337-7998



APPLICATION FOR SUPPORTIVE INSTRUCTION

Medical Reason

According to 14 DE Admin Code §§ 931.0 through 931.1 “**Supportive Instruction**’ is an alternative educational program provided at home, in a hospital or at a related site for a student temporarily at home or hospitalized by a sudden illness, injury, episodic flare up of a chronic condition or accident considered to be of a temporary nature. Procedures for eligibility shall be limited to appropriate certification that the student cannot attend school.”

In order for a student to be eligible for supportive instruction (homebound) a physician must certify that a student **cannot** attend school **for at least ten (10) school days** (14 DE Admin Code §§ 932.1.1). Please provide the following information:

Student Name: _____	Birthdate: _____
School: _____	Grade: _____
Parent/Guardian: _____	
Home Telephone: _____	Work Telephone: _____
Address: _____	

To be completed by the treating physician:

Attach documentation on your letterhead that includes the **medical diagnosis, justification of medical exclusion from school, and a plan for the student to return to school.** Indicate any restrictions or limitations brought about by this student’s condition of which the supportive instruction teacher should be aware. Include information about any possible health hazards to the instructor.

Dates of requested exclusion (not to exceed a 6 week period): _____ to _____

As the treating physician, I certify that the above information, as well as the attached documentation is true and accurate.

_____ Physician Print Name	_____ Physician Signature	_____ Date
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To be completed by the parent/guardian:

I give permission to the Woodbridge School District to obtain and share information regarding the need for supportive instruction from the certifying physician.

_____ Parent/Guardian Print Name	_____ Parent/Guardian Signature	_____ Date
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