NEWPORT NEWS PUBLIC SCHOOLS

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

Mail or Fax Forms:

Homebound Office
1241 Gatewood Road
Newport News, VA 23601
{757) 591-4695 (fax)