BEAUFORT COUNTY SCHOOLS
PROGRAM FOR HOMEBOUND CHILDREN

PHYSICIAN'S STATEMENT

Child's Name: _____ DOB: _____

Address: _____

City/State/Zip Code: _____

Parent's Name: _____

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Nature and Extent of Handicap:

Physical and/or Psychological Limitations Under Which Child Can Perform School Work Successfully:

Anticipated length of time child is expected to be incapacitated:

Physician's Name: _____

Physician's Signature: _____

Date: _____ Phone No.: _____

*****Please return this completed form to the Principal.*****
Revised 2023